

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:

County Allegany
 City or town Flintstone
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 32 Years
 Hospital, institution, or street address where death occurred:
Rural
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Flintstone
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rural
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Sarah Jane Alt

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Enoch Alt
 6.(c) If alive, give age 82 years
 7. Birth date of deceased (mo., day, yr.) January 17 1872
 8. AGE: Years 76 Months 3 Days 17 If less than one day
hrs.min.

9. Birthplace Landis, Penelton Co., W. Va.
 (Town, county, and state)
House
 10. Usual occupation
 11. Industry or business

12. Name Isaac Judy
 13. Birthplace West Virginia
 14. Maiden name Sena Mallow
 15. Birthplace West Virginia

16. Informant Mrs. Dayton Dolly
 Address Flintstone W. Va., Md.

17. Burial Date thereof 5/7/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Glendale Cemetery
 Location Flintstone, Md.

18. Funeral director William H. Kight
 Address Cumberland, Md.

19. 5/5/48 19 1948
 (Date rec'd by registrar) Registrar Nina L. Bender

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 19 48 at 5:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 15 19 48, to May 4 19 48
 and that I last saw her alive on May 4 19 48

Immediate cause of death Carcinoma of colon
 DURATION

Due to

Due to

Other conditions Metastasis to lungs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Benedict Skitaralis M.D.Address R² Cumberland, Md. Date signed 5/5/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 10 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:

County Allegany
City or town Mt. Savage Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany
City or town Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Daniel (Ruth Miller) Arnold

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife Daniel Arnold

7. Birth date of deceased (mo., day, yr.) Feb. 27- 1883
6. (c) If alive, give age 66 years

8. AGE: Years Months Days If less than one day
65 2 15 hrs. min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

12. Name Louis Miller

13. Birthplace Cumberland Md.

14. Maiden name Elizabeth Faupel

15. Birthplace West Virginia

16. Informant Daniel Arnold,

Address Mt. Savage, Md.

17. Burial Date thereof May 17, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Georges Cemetery,

Location Mt. Savage, Md.

18. Funeral director J. R. Durst,

Address Frostburg, Md.

19. May 17 19 48 Veronica M. Deming
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 19 48 at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. er Dead May 14 19 48

Immediate cause of death

Cerebral hemorrhage due to at
a rupture of a cerebral vessel once
while in a convulsion

Due to

Due to

Other conditions Had a brain tumor removed in

right temporal region 4 yrs. ago.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner Allegany

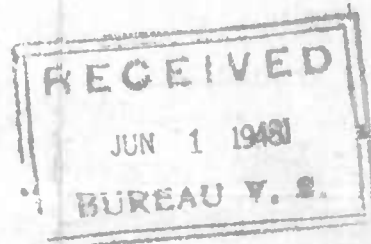
23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.

Address Cumberland Md. Date signed 5.15-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr Paul R. Wilson

Reg. Dist. No. 04502

1. PLACE OF DEATH:

County Allegany
 City or town Luke
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 48 years
 Hospital, institution, or street address where death occurred:
Fairview Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Luke
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Fairview Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

ARVID HARMON BENSON

3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>	
6. (b) Name of husband or wife <u>Bonnie Brunbaugh Benson</u>			
7. Birth date of deceased (mo., day, yr.) <u>December 28, 1899</u>			
8. AGE: Years <u>48</u>	Months <u>4</u>	Days <u>27</u>	If less than one dayhrs.min.
9. Birthplace <u>Luke, Allegany, Maryland</u> (Town, county, and state)			
10. Usual occupation <u>Laborer</u>			
11. Industry or business <u>Paper Mill</u>			
12. Name <u>Andrew Benson</u>			
13. Birthplace <u>Sweden</u>			
14. Maiden name <u>Bessie Johnston</u>			
15. Birthplace <u>Sweden</u>			
16. Informant <u>Mrs. Bonnie B. Benson</u> Address <u>Luke, Maryland</u>			
17. Burial <u>Philos Cemetery</u> (Burial, cremation, or removal. Which?) Date thereof <u>May 28, 1948</u> (month) (day) (year) Cemetery or crematory <u>Westernport, Maryland</u> Location <u>Ellsworth S. Boal</u>			
18. Funeral director <u>Westernport, Maryland</u> Address			
19. <u>May 28</u> 19 <u>48</u> (Date rec'd by registrar) Registrar			

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 19 48 at 9:30 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 26 19 48 to May 26 19 48
 and that I last saw him alive on May 26 19 48
 Immediate cause of death Hemiplegia and other paralysis of unspecified origin.
 Due to High blood pressure (idiopathic)
 Due to Chronic Nephritis
 Other conditions
 (Include pregnancy within 3 months of death)
 Major findings of operations None
 Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following: None
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE Paul R. Wilson, M.D.
 Address Piedmont, W. Va. Date signed May 27, 1948

DURATION

1 Day
1 Year
1 Year

RECEIVED

MAY 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County **ALLEGANY** COUNTY
City or town **CUMBERLAND, MARYLAND**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? **154 DAYS**
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? **154 DAYS**

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State **MARYLAND** County **ALLEGANY**
City or town **WESTERNPORT**
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME
PAUL BISHOP

3. (b) Social Security Number

None

4. Sex **MALE** 5. Color or race **WHITE** 6.(a) Single, married, widowed, or divorced **SINGLE**
6.(b) Name of husband or wife _____
7. Birth date of deceased (mo., day, yr.) **December 16, 1928** 6.(c) If alive, give age _____ years
8. AGE: Years **19** Months **5** Days **13** If less than one day _____ hrs. _____ min.

9. Birthplace **WESTERNPORT, ALLEG MARYLAND**
(Town, county, and state)

10. Usual occupation **NONE**

11. Industry or business _____

FATHER 12. Name **JOHN L. BISHOP**
13. Birthplace **MARYLAND**

MOTHER 14. Maiden name **HAZEL, BISHOP**

15. Birthplace **MA RYLAND**

16. Informant **Hospital Record**

Address _____
17. **Burial** Date thereof **June 2, 1948**
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory **Bloomington Cem.**
Location **Bloomington, Md**

18. Funeral director **Ellsworth A. Boal**
Address **Westernport, Md.**

19. **June 1, 1948** **W.H. Fantz, M.D.**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **May 27, 1948** at **8:50 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Nov 15, 1947** to **May 27, 1948**
and that I last saw him alive on **4/27/48**

Immediate cause of death **Myocardial Failure** DURATION _____

Due to **Rheumatic Fever** 5 yrs

Other conditions _____
(Include pregnancy within 3 months of death)

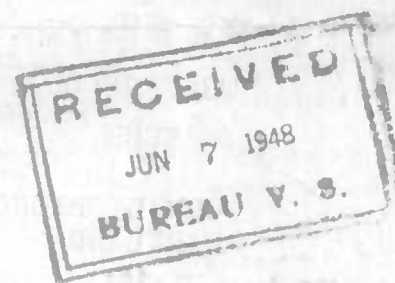
Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE **W.H. Fantz, M.D.**
Address **Cumberland, Md.** Date signed **5/31/48**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The doctor's age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County... Allegheny
 City or town... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... 6 mos.
 Hospital, institution, or street address where death occurred:
Wm. H. Hospital
 How long in hospital or institution?... 6 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... 2nd County... Allegheny
 City or town... Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... Park Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Charles Stanley Bluxbaugh

3. (b) Social Security Number

✓

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 12 - 1864

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

831117

hrs.

min.

9. Birthplace

Unknown

(Town, county, and state)

10. Usual occupation

Teacher

11. Industry or business

Go. P. P. Co.

FATHER

12. Name

Peter Bluxbaugh

13. Birthplace

Unknown

MOTHER

14. Maiden name

Elizabeth Sharff

15. Birthplace

Unknown

16. Informant

Mrs. Sue Bluxbaugh

Address

P.O. Box 1 Frostburg, Md.

17.

(Burial, cremation, or removal, which?)

Date thereof

5-31-1948

Cemetery or crematory

Allegheny Cemetery

Location

Frostburg, Md.

18. Funeral director

Joseph W. Weller

Address

Frostburg, Md.

19.

(Date rec'd by registrar)

19

6-3-48

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 29

19

48 at 1:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1

19

48, toMay 29

19

48

and that I last saw him

alive on

May 29

19

48

Immediate cause of death

Chronic Myocarditis

DURATION

Due to

The Nephritis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

MOM Lane

M. D. or other

Address... Frostburg, Md. Date signed June 2, 1948

RECEIVED

JUN 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04565

Reg. Dist. No. 9

1. PLACE OF DEATH:

County AlleghenyCity or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Midland
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

James Clise Blubaugh

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.)

May 23, 1948

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

9 hrs. 46 min.

9. Birthplace

Frostburg, Allegheny, Md.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER

12. Name

James Walter Blubaugh

13. Birthplace

Lonaconing, Md.

MOTHER

14. Maiden name

Helen Elizabeth Clise

15. Birthplace

Midland, Maryland

16. Informant

Mrs. J. W. Blubaugh

Address

Midland, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 24, 1948
(month) (day) (year)

Cemetery or crematory

Allegheny Cemetery

Location

Frostburg, Md.

18. Funeral director

M. Eichhorn

Address

Lonaconing, Md.

19. 5-24

19. 48

(Date rec'd by registrar)

Ms. Nancy V. Rae

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 19 48, at 9:50 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/23 19 48, to 5/23 19 48, and that I last saw him alive on 5/23 19 48.

Immediate cause of death

Atherosclerosis

DURATION

5 hrs

Due to

[Toxemia of pregnancy of mother]

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

Hilda J. Wall-Walters, Md.

M. D. or other

Address Frostburg, Md. Date signed 5/24/48

CERTIFICATE OF DEATH

RECEIVED
MAY 26 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The contents of this certificate are especially important. Physicians: please write the causes of death clearly and legibly.

DR. W. F. WILLIAMS
Evidence for change of age
shown on:

FILE No. G 116 JUL 9 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County..... ALLEGANY
City or town..... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution?..... 7 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... W. VA. County..... HAMPSHIRE, W. VA.
City or town..... POINTS, W. VA.
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war..... ☒

3.(a) FULL NAME

MR. DEWEY ARTHUR BOWEN

3.(b) Social Security Number

232-26-0798

4. Sex..... MALE 5. Color or race..... WHITE 6.(a) Single, married, widowed, or divorced..... MARRIED

6.(b) Name of husband or wife..... MAMIE ELIZABETH DELAWDER

7. Birth date of deceased (mo., day, yr.)..... JULY 12, 1906 6.(c) If alive, give age..... 31 years

8. AGE: Years..... 41 Months..... 42 Days..... 10 If less than one day..... 3 hrs. min.

9. Birthplace..... Hamptshire County, West Virginia
(Town, county, and state)

10. Usual occupation..... BALTIMORE & OHIO RAILROAD

11. Industry or business..... Laborer

12. Name..... MR. WILLIAM ARTHUR BOWEN

13. Birthplace..... WEST VIRGINIA

14. Maiden name..... ANNIE MAY WRIGHT

15. Birthplace..... MARYLAND

16. Informant..... MEMORIAL HOSPITAL

Address..... MEMORIAL AVE., CUMBERLAND, MD.

17. Burial..... Date thereat..... May 15, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Mary's Cemetery

Location..... St. Mary's, Sheswell, W. Va.

18. Funeral director..... Mr. McKen

Address..... Augusta, W. Va.

19. May 15, 1948..... W. F. Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... MAY 15, 1948 at 3:10 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 5-14-1948 to 5-15-1948 and that I last saw him alive on 5-15-1948

Immediate cause of death.....

DURATION

Rocky Mountain spotted fever (WV)
Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... None

Date of op..... None

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... W. F. Williams

Address..... Cumberland Date signed..... 5/15/48

RECEIVED

MAY 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

04507

93d

1. PLACE OF DEATH: Allegany
County.....
Cumberland,
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
837 Gephart Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 837 Gephart Drive
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

ALICE M. CADDEN

3. (b) Social Security Number
None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife James H. Cadden
7. Birth date of deceased (mo., day, yr.) March 7, 1868
8. AGE: Years 80 Months 2 Days 20 It less than one day
hrs. min.

9. Birthplace Bloomington, Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER 12. Name Andrew Mullen
13. Birthplace Maryland
MOTHER 14. Maiden name Clementine Pattison
15. Birthplace Maryland

16. Informant Miss Eleanor Cadden
Address 837 Gephart Drive, Cumberland,

17. Burial Date thereof May 29, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory S. S. Peter & Paul
Location Cumberland, Md.

18. Funeral director H. Wayne George
Address Cumberland, Md.

19. May 29, 1948 W. H. Kuntz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27, 1948, at 4:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26/48 to May 27, 1948
and that I last saw him alive on May 28, 1948
Immediate cause of death Cardiac dilatation DURATION 1.2 hrs

Due to Chronic myocarditis 7 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. P. Oriskany M. D. or other
Address 41 Green St. Date signed May 28, 1948

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 2 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04508

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: Allegany
 County Cumberland
 City or town (if outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Allegany Hospital
 How long in hospital or institution? 54 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 728 Hill Top Drive
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME
Alice Carney

3. (b) Social Security Number
None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife J. Joseph Carney Jr.
 7. Birth date of deceased (mo., day, yr.) March 12, 1900 6.(c) If alive, give age 49 years
 8. AGE: Years 48 Months 1 Days 24 If less than one day
 hrs. min.

9. Birthplace Cumberland, Allegany, Maryland
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Frank J. Graebenstein
 13. Birthplace Cumberland, Md.

MOTHER 14. Maiden name Anna Miltenberger
 15. Birthplace Ortana, Penna.

16. Informant Mr. J. Joseph Carney Jr.
 Address 728 Hilltop Drive Cumberland, Md

17. Burial Date thereof May 10, 1948
 (Burial, cremation, or removal. White?) (month) (day) (year)
 Cemetery or crematory St Marys' Cem.
 Location Cumberland, Md.

18. Funeral director Charles L. George
 Address Cumberland, Md.

19. May 8, 1948 W.R. Tantz, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6, 1948 at 7:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
3-12-48 1948 to 5-5-48 1948
 and that I last saw him alive on 5-5-48 1948

Immediate cause of death
Mesenteric thrombosis
volvulus: intestinal obstruction

Due to

Due to

Other conditions Toxemia: fecal
perforation
 (Include pregnancy within 3 months of death)

Major findings of examination Perforation of small intestine
volvulus of intestine Date of op. 3-12-48

Autopsy results None made
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Moone of injury Injured at work?

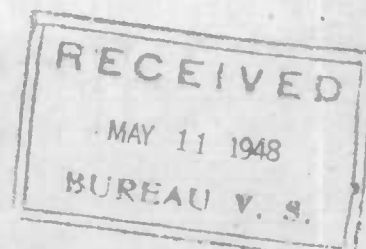
23. SIGNATURE W.R. Tantz, M.D. M. D. or other

Address Allegany Date signed 5-8-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Evidence for correction of MARYLAND STATE DEPARTMENT OF HEALTH
questions 7 & 8 shown on:

2411 N. Charles St., Baltimore

61

04509

8

FILE No. G 116 JUN -2 1948

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegheny
City or town Condit - Route 1 - Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 1/2 years
Hospital, institution, or street address where death occurred: L
How long in hospital or institution? L

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegheny
City or town Rural - Condit - Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. L
(If rural, give LOCATION)
2.(a) If veteran, name war L

3. (a) FULL NAME

Mary Cesnick

3. (b) Social Security Number

L

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Joseph Cesnick

7. Birth date of deceased (mo., day, yr.) Jan 9, 1878 6.(c) If alive, give age L years

8. AGE: Years 70 Months 3 Days 28 If less than one day L hrs. L min.

9. Birthplace Budapest
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own home

12. Name Yekrase

13. Birthplace Hungary

14. Maiden name Katherine Cesnick

15. Birthplace Hungary

16. Informant John Cesnick

Address Midland, Md

17. Burial, cremation, or removal, Which? Burial Date thereof May 10, 1948
(month) (day) (year)

Cemetery or crematory Belvedere Cemetery

Location Midland, Md

18. Funeral director M. Eichhorn

Address Loracross, Md.

19. May 10 19 48 Janet M. Boal
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 19 48 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 48 to May 7 19 48

and that I last saw him alive on May 7 19 48

Immediate cause of death C-V-R disease

Due to Shabets Mellitus

Due to L

Other conditions L

(Include pregnancy within 8 months of death)

Major findings of operations L

Date of op. L

Autopsy results L

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide L Date of L

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) (City or town) (County) (State)

Means of injury L Injured at work? L

23. SIGNATURE W. E. Gatterman M.D.

Address Frostburg, Md. Date signed 5/10/48

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

04510

1. PLACE OF DEATH:

County **Allegany**
 City or town **Cumberland**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **4 years**
 Hospital, institution, or street address where death occurred:
Allegany Hospital
 How long in hospital or institution? **2 hours**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State **Maryland** County **Allegany**
 City or town **Cumberland**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **19 Washington St.**
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

John F. Coffman

3. (b) Social Security Number

227-16-8056

4. Sex Male	5. Color or race White	6. (a) Single, married, widowed, or divorced Single
6. (b) Name of husband or wife		
6. (c) If alive, give age years		
7. Birth date of deceased (mo., day, yr.) August 12, 1914		
8. AGE: Years 33	Months 9	Days 17 hrs. min.

9. Birthplace **Bell Buckle, Bedford, Tennessee**
 (Town, county, and state)
 10. Usual occupation **Chemist**
 11. Industry or business **Celanese Corp. of America**
 12. Name **W. C. Coffman**
 13. Birthplace **Bedford Co. Tenn.**
 14. Maiden name **Annie May Fletcher**
 15. Birthplace **Bedford Co. Tenn.**

16. Informant **Mr. W. H. Carter**
 Address **Amherst, Virginia**
 17. Removal **Removal** Date thereof **May 31, 1948**
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory **Hazel Cemetery**
 Location **Bell Buckle, Tennessee**
 18. Funeral director **William H. Kight**
 Address **Cumberland, Md.**

19. **May 31, 1948** **W. H. Kight, M.D.**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **May 29, 1948** at **6:45 P.M.**
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Sept 1946** to **May 29, 1948**
 and that I last saw him alive on **May 29, 1948**
 Immediate cause of death **Chronic Endocarditis**
 Due to **Chronic Hypertension**
 Due to **?**
 Other conditions **Acute Influenza**
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

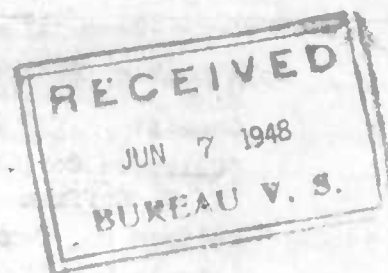
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE **W. H. Kight**
 M. D. or other
 Address **Amherst, Va.** Date signed **5/30/48**

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE, WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04509

1. PLACE OF DEATH:

County AlleganyCity or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:

Myers' HospitalHow long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County AlleganyCity or town Eastport, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Richard Millard Connors

3. (b) Social Security Number

220-10-8610

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Lorina A. Connors6. (c) If alive, give age 57 years

7. Birth date of

deceased (mo., day, yr.)

Mar. 28 - 1889

8. AGE:

Years

Months

Days

It less than one day

5930

hrs.

min.

9. Birthplace Eastport, Md.

(Town, county, and state)

10. Usual occupation

Custodian

11. Industry or business

Belarusy Corp.

FATHER

12. Name Lorina A. Connors13. Birthplace Eastport, Md.

MOTHER

14. Maiden name Burns15. Birthplace Pittsburgh, Pa.16. Informant Mrs. P. M. ConnorsAddress Eastport, Md.17. Burial (burial, cremation, or removal. Which?) BurialDate thereof 5-30-1948

(month) (day) (year)

Cemetery or crematory Eastport CemeteryLocation Eastport, Md.18. Funeral director James H. BakerAddress Frostburg, Md.19. 5-29-48 Mrs. Nancy R. Rie

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1948 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 5 1948 to May 28 1948and that I last saw him alive on May 25 1948

Immediate cause of death

Chronic Myocarditis

DURATION

5 mo

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

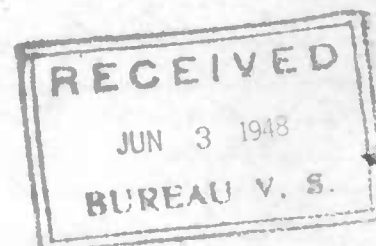
Manner of injury

Injured at work?

23. SIGNATURE W. M. C. Rie

M. D. or other

Address Frostburg, Md. Date signed 5-28-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04512 9

1. PLACE OF DEATH: **Allegany**
 County.....
 City or town..... **Frostburg**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **all his life**
 Hospital, institution, or street address where death occurred:
28 W. Mechanic St.
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... **Maryland** County..... **Allegany**
 City or town..... **Frostburg**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... **28 W. Mechanic St.**
 (If rural, give LOCATION)
 2.(a) If veteran, name War.....

3. (a) FULL NAME **JOHN G. COOK**

3. (b) Social Security Number
215-10-4495

4. Sex **Male** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Married**
 6. (b) Name of husband or wife..... **Edith R. Cook**
 6. (c) If alive, give age..... **63** years
 7. Birth date of deceased (mo., day, yr.) **March 26, 1881**
 8. AGE: Years **67** Months **2** Days **2** If less than one day..... hrs. min.

9. Birthplace..... **Moscow, Allegany, Maryland**
 (Town, county, and state)
 10. Usual occupation..... **Mortician**
 11. Industry or business..... **Funeral home**
 12. Name..... **William H. Cook,**
 13. Birthplace..... **England**
 14. Maiden name..... **Janet Morton,**
 15. Birthplace..... **Scotland**

16. Informant..... **Dr. Albert Cook,**
 Address..... **Frostburg, Md.**

17. **Burial** Date thereof..... **June 1, 1948**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... **Allegany Cemetery,**
 Location..... **Frostburg, Md.**

18. Funeral director..... **J. R. Durst,**
 Address..... **Frostburg, Md.**

19. **6-1** 19 **48** **Mrs. Nancy V. Rose**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **29 May** 19 **48** at **8** **30** **A** M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
18 **cn.** **1947** 19..... to..... **29** **May** 19 **48**
 and that I last saw him alive on..... **27** **May** **1948** 19.....

Immediate cause of death.....
Carcinoma stomach
Generalized carcinomatosis
 DURATION **18 months**

Due to.....
 Due to.....
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... **adenocarcinoma of**
stomach with metastases Date of op. **8/2/47**
 Autopsy results..... **not done**
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE..... **W. Alfred Van Dine** M. D. or other
 Address..... **Cumtland, Md.** Date signed..... **30 May 48**

RECEIVED

JUN 3 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04513

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Sunbury Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. Sunbury Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Harry Lee Cornelius Sr.

3. (b) Social Security Number

214 07 1539

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Amanda Hill

7. Birth date of

deceased (mo., day, yr.)

Nov. 29 1888

6. (c) If alive, give age

57 years

8. AGE:

Years

Months

Days

If less than one day

59514

hrs.

min.

9. Birthplace

Pittsburgh, Pa. (Allegheny County)
(Town, county, and state)

10. Usual occupation

Retired Purchasing Agent

11. Industry or business

Celanese Plant

FATHER

12. Name

Edgar F. Cornelius

13. Birthplace

Penna.

MOTHER

14. Maiden name

Elizabeth Evans

15. Birthplace

Penna.

16. Informant

Mrs H.L. Cornelius Sr.

Address

Sunbury Ave. Cumberland, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof May 15 1948
(month) (day) (year)

Cemetery or crematory

Hill Crest Cemetery

Location

Cumberland, Md.

18. Funeral director

H. Wayne George

Address

Cumberland, Md.

19.

(Date registered by registrar)

19

48Walter R. Trout M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 19 48, at 4:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 10 - 19 48 to May 13 19 48
and that I last saw him alive on May 13 19 48

Immediate cause of death

Chronic Myocarditis
Coronary Thrombosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. B. Winkler

M. D. or other

Address

49 Green St

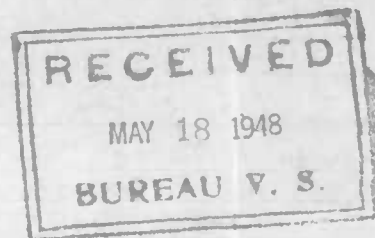
Date signed

5/14/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04514

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

43 Offutt St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 43 Offutt St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Crabtree

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white widower6. (b) Name of husband or wife Pacey Thomas

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26- 18768. AGE: Years Months Days It less than one day
71 9 23 hrs. min.9. Birthplace Old Town Md.
(Town, county, and state)10. Usual occupation Bartender - Retired

11. Industry or business

FATHER 12. Name Joseph Crabtree
13. Birthplace Maryland
MOTHER 14. Maiden name Lydia Maryland
15. Birthplace Maryland16. Informant (son) Irvin Crabtree
Address 43 Offutt St Cumberland Md.17. Burial Date thereof May 22 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rice Hill Cemetery
Location Cumberland Md.18. Funeral director Louis Stein Inc.
Address Cumberland Md.19. May 21, 1948 W.D. Fautz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 19 48 at 10.25 P.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw him in Dead May 20 19 48Immediate cause of death Angina Pectoris
DURATION at onceDue to Coronary sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner Allegany Co23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. orAddress Cumberland Md. Date signed 5.20.48

RECEIVED

MAY 25 1948

BUREAU V. S.

W.F.WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04515 4

1. PLACE OF DEATH:

County ALLEGANY
 City or town CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 HOURS
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution? 7 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County GARRETT
 City or town FRIENDSVILLE, MD.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

MRS. MINNIE CUSTER

3. (b) Social Security Number

None

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife Mr. DAVID CUSTER

7. Birth date of deceased (mo., day, yr.) MARCH 7, 1866 6. (c) If alive, give age 86 years

8. AGE: Years 82 Months 2 Days 14 If less than one day 7 hrs. min.

9. Birthplace MARYLAND, Sang Run, Garrett Co.
 (Town, county, and state)

10. Usual occupation HOUSE WIFE11. Industry or business Own home12. Name David Harrison Friend13. Birthplace Garrett County, Maryland14. Maiden name Mary Pike15. Birthplace Garrett County, Maryland16. Informant MEMORIAL HOSPITALAddress MEMORIAL AVENUE, CITY17. Burial Date thereof May 23, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Blooming RoseLocation Friendsville, Md18. Funeral director Emory BoldenAddress Oakland, Md19. May 27, 1948 W. F. Williams, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 21, 1948 at 5:15 A.M.21. I CERTIFY that death occurred on the date above stated, that I attended deceased from May 20, 1948 to May 21, 1948and that I last saw him alive on May 20, 1948Immediate cause of death Coronary Thrombosis DURATIONGeneralized Arterio-SclerosisInsufficiencies of age.

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

Signature W. F. Williams M. D. or otherAddress Cumberland Date signed 5/21/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04516

CERTIFICATE OF DEATH

940

Reg. Dist. No.

4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 54 years

Hospital, institution, or street address where death occurred:

Queen City Hotel

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. Queen City Hotel
(If rural, give LOCATION)2. (a) If veteran, name war World War I

3. (a) FULL NAME

Francis Dahl

3. (b) Social Security Number

214-05-9377

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) April 6 - 1893

8. AGE:

Years

Months

Days

If less than one day

54116

hrs. min.

9. Birthplace

Carrigansville Md.
(Town, county, and state)

10. Usual occupation

cook

11. Industry or business

Queen City Hotel

FATHER

12. Name

William Dahl

13. Birthplace

Germany

MOTHER

14. Maiden name

Rachel Beals

15. Birthplace

Pennsylvania

16. Informant

Henry Dahl

Address

Queen City Hotel, Cumberland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

May 25, 1948
(month) (day) (year)

Cemetery or crematory

Sts Peter & Paul's Cemetery

Location

Cumberland, Md.

18. Funeral director

John J. Nefer

Address

Cumberland, Md.

19. May 25 1948

(Date rec'd by registrar)

W.R. Frantz, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 19 48 at 5 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

_____ 19 _____ to _____ 19 _____

and that I last saw him alive Dead May 22 19 48

Immediate cause of death

Coronary occlusionDue to coronary sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

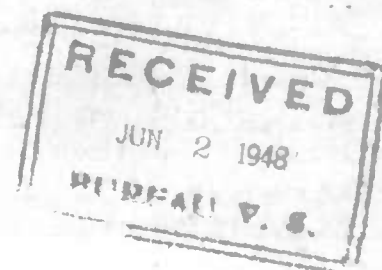
Deputy Medical Examiner Prognosis by23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. of _____Address Cumberland Md. Date signed 5-22-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1572

04517

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County AlleganyCity or town Cresaptown
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Jerry Alanis

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced ✓

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 1, 19488. AGE: Years _____ Months _____ Days 1 If less than one day _____ hrs. _____ min.9. Birthplace Frostburg, Allegany, Md.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

12. Name Johu Theodore Alanis Jr.13. Birthplace Frostburg, Md.14. Maiden name Jeane Louise Gaudin15. Birthplace Royal Oak, Mich.16. Informant Mr. Johu T. AlanisAddress Cresaptown, Md.17. Burial Date thereof 5-3-1948
(Burial, cremation, or removal, When) (month) (day) (year)Cemetery or crematory Valle Summit CemeteryLocation Valle Summit, Md (Frostburg)18. Funeral director Johu T. AlanisAddress Cresaptown, Md.19. 5-3 19 48 Mrs. Nancy H. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 19 48 at 11 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 48 to May 2 19 48and that I last saw him alive on May 2 19 48

Immediate cause of death _____ DURATION _____

Patient foreman over 1 day.Due to Premature birth 7 1/2 mos.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

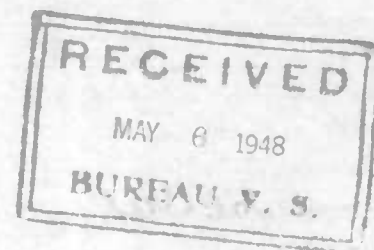
Means of injury _____ Injured at work? _____

23. SIGNATURE H.C. Siehl, M.D. M. D. or other _____Address Frostburg, Md. Date signed 5/2/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

04518

131a

1. PLACE OF DEATH:

County Allegany
 City or town Summersburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:
Allegany Hospital
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Gonaconing
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1
 (If rural, give LOCATION)
 2. (a) If veteran, name war no

3. (a) FULL NAME

Dorah Washington Dawson

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widowed

6. (b) Name of husband or wife 6. (c) If alive, give age

Ida H. Fortz 1 years

7. Birth date of deceased (mo., day, yr.) 8. AGE: Years Months Days If less than one day

Mar. 2, 1864 94 2 26 hrs. min.

9. Birthplace (Town, county, and state)

Dawson, Maryland

10. Usual occupation

Trackman United

11. Industry or business

Md. Coal Co. of Gonaconing

12. Name

James O. Dawson

13. Birthplace

Dawson, Md.

14. Maiden name

Anna B. Dawson

15. Birthplace

Dawson, Md.

16. Informant

Mrs. Salisbury

Address

Gonaconing, Md.

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Burial May 31, 1948

Cemetery or crematory

Oak Hill Cemetery

Location

Gonaconing, Md.

18. Funeral director

Mr. Eickhorn

Address

Gonaconing, Md.

19. (Date rec'd by registrar)

May 31, 1948

Registrar

W. H. Fortz, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1948 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 28 1948 to May 28 1948

and that I last saw him alive on May 28 1948

Immediate cause of death

Cerebral Hemorrhage

DUE TO

Hypertension

DUE TO

Vascular Disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

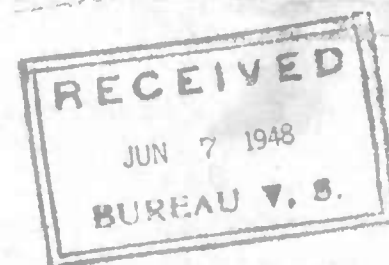
23. SIGNATURE

James O. Dawson

Address

50 Presby St

Date signed 5/29/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04519

Reg. Dist. No. 4

1. PLACE OF DEATH: Allegany

County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 10 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Virginia County Mineral

City or town Ridgely
(If outside city or town limits, write RURAL and give nearest town)Street No. 6 Jones St.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

GEORGE WASHINGTON DAWSON

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

8. (b) Name of husband or wife Rosella Martin

8. (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) July 22, 1878

8. AGE: Years 69 Months 9 Days 12 If less than one day hrs. min.

9. Birthplace Keyser, W. Va.
(Town, county, and state)

10. Usual occupation Trackman

11. Industry or business Western Md. Railway

12. Name Jacob Dawson

13. Birthplace W. Va.

14. Maiden name Julia Spencer

15. Birthplace W. Va.

16. Informant Mrs. Frank Travis

Address 1 Barncoord St., Ridgeley, W. Va.

17. Burial Date thereof May 7, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Zion Cem.

Location Near Short Gap, W. Va.

18. Funeral director H. Wayne George

Address Cumberland, Md.

19. May 6, 1948 W. H. Tautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4, 1948, at 11:57 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 4, 1948, to May 4, 1948
and that I last saw him alive on May 4, 1948

Immediate cause of death

Cerebral Hemorrhage

DURATION

18 hours

Due to Hypertensive Cardiac -
vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address 122 Barb St. Cumberland Date signed 5/6/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 11 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegheny Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 132 N. Centre St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ada Lechlitter Dendrenos

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Gregory Dendrenos

7. Birth date of

deceased (mo., day, yr.)

August 22, 1922

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

25105

hrs.

min.

9. Birthplace

Short Gap, West Va.
(Town, county, and state)

10. Usual occupation

Witness

11. Industry or business

Victory Girl

12. Name

Gregory Lechlitter

13. Birthplace

W. Va.

14. Maiden name

Mary Mc Carthy

15. Birthplace

W. Va. Maryland

16. Informant

Gregory Dendrenos

Address

132 N. Centre St, Cumberland, Md

17.

Funeral
(Burial, cremation, or removal. Which?)

Date thereof

June 1, 1948
(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Cumberland, Md.

18. Funeral director

Louis Stein, Inc.

Address

Cumberland Maryland

19.

May 28, 1948
(Date rec'd by registrar)W. F. Frantz, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27, 1948, 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1, 1948, to May 27, 1948and that I last saw her alive on May 27, 1948

Immediate cause of death

surgical shock

DURATION

3 hours

Due to

following cesarean

Due to

perforated intestine

Other conditions

perforated intestine

(Include pregnancy within 3 months of death)

Major findings of operations

cesarean sectionDate of op. 5-27-48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

L. Stein (M.D.)

M. D. or other

Address

59 S. Green St.Date signed 5-27-48

RECEIVED

JUN 2 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04521

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? All of life
 Hospital, institution, or street address where death occurred:
Buckingham Road, The Dingle
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 835 Buckingham Rd.
 (If rural, give LOCATION)
 2. (a) If veteran, name war World War 2

3. (a) FULL NAME

Howard Harlen Dickey Jr.

3. (b) Social Security Number

214-05-9363

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Helen Dickey
 6. (c) If alive, give age 38 years
 7. Birth date of deceased (mo., day, yr.) Sept. 12-1911
 8. AGE: Years 36 Months 8 Days 19 If less than one day _____ hrs. _____ min.

9. Birthplace Cumberland Md.
 (Town, county, and state)
 10. Usual occupation Kelly (Accountant)
 11. Industry or business Automobile tires
 12. Name Howard Harlen Dickey
 13. Birthplace Philadelphia, Pa.
 14. Maiden name Annie Gibson Roberts
 15. Birthplace Cumberland Md.
 16. Informant Mrs. Howard H. Dickey Jr.
 Address 835 Buckingham Rd, City
 17. Burial Date thereof May 4, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Cumberland, Md.
 18. Funeral director John O. Halford
 Address 125 S. Liberty St.
 19. May 3 19 48 W. P. Trant, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 19 48 at 12.05 M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____
 and that I last saw him Dead May 2 19 48
 Immediate cause of death
Intracranial hemorrhage due at once
to a fracture of the skull
* caused by a 38 caliber
revolver bullet entering right
* to temple area.
Wound self inflicted.
 Other conditions _____

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results as above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide suicide Date of 5-2-48
 Where did injury occur? Home Cumberland Allegany Md.
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Home
 Means of injury 38 Caliber gun Injured at work? No.
Deputy Medical Examiner - Allegany Co
 23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
 M. D. or _____
 Address Cumberland Md. Date signed 5-3-48

RECEIVED

MAY 11 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Alle ganyCity or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)Street No. 2 East Main Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Jonas J. Durst

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Sally W. Layman

7. Birth date of deceased (mo., day, yr.)

August 24, 18576.(c) If alive, give age 77 years

8. AGE:

Years

Months

Days

If less than one day

90828

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Retired - Funeral Director

11. Industry or business

MOTHER FATHER

12. Name

Jerimaha Durst

13. Birthplace

Maryland

14. Maiden name

Anna Beechy

15. Birthplace

Maryland

16. Informant

Memorial Hospital

Address

Cumberland, Maryland

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

May 24 1948

(month) (day) (year)

Cemetery or crematory

Allegany Cemetery

Location

Frostburg, Md.

18. Funeral director

Louis Stein, Inc.

Address

Cumberland, Md.

19.

May 24, 1948

(Date rec'd by registrar)

W.R. Brantz, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22, 1948 at 4:05A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-22-48 to May 22-48
and that I last saw him alive on May 21-48

Immediate cause of death

Myocardialfollowing

Due to

Myocardial Infarction

Due to

Fracture Rt femur

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/22/48Where did injury occur? Frostburg (City or town) md (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Tipped over a rug pole Injured at work? 6/30/48

23. SIGNATURE

L.M. Wilson, Jr.

M. D. or other

Address Cumberland, Md. Date signed 5-24-48

MARGIN RESERVED FOR BINDING

VS/A15 9-45-15M

VS/A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

04522

1860

RECEIVED

JUN 2 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04523

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County.....ALLEGANY
 City or town.....CUMBERLAND, MARYLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....17 DAYS
 Hospital, institution, or street address where death occurred:
 MEMORIAL HOSPITAL
 How long in hospital or institution?.....17 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State.....MARYLAND County.....GARRETT
 City or town.....GRANTSVILLE, MD
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

WILLIAM D. EDGAR

3. (b) Social Security Number

214-03-7107

4. Sex.....MALE 5. Color or race.....WHITE 6. (a) Single, married, widowed, or divorced.....MARRIED
 6. (b) Name of husband or wife.....DORA E. KAHL
 6. (c) If alive, give age.....43 years
 7. Birth date of deceased (mo., day, yr.).....FEBRUARY 4, 1888
 8. AGE: Years.....60 Months.....2 Days.....28 It less than one day.....hrs.min.

9. Birthplace.....PITTSBURGH, PENNSYLVANIA
 (Town, county, and state)
 10. Usual occupation.....BODY & FENDER WORKER
 11. Industry or business.....HARVEY GORTNER MOTOR SERV.
 12. Name.....WILLIAM H. EDGAR
 13. Birthplace.....MARYLAND
 14. Maiden name.....AMELIA KAHL
 15. Birthplace.....MARYLAND

16. Informant.....MEMORIAL HOSPITAL
 Address.....MEMORIAL AVE., CUMBERLAND, MD

17. Burial, cremation, or removal, Which?.....Burial Date thereof.....May 5, 1948
 (month) (day) (year)
 Cemetery or crematory.....Grantsville Cemetery
 Location.....Grantsville, Maryland
 18. Funeral director.....W. J. Myers, Jr.
 Address.....Myersdale, Pa.
 19. May 3, 1948 W. H. Frantz, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....MAY 2, 1948, at 12:05 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 Apr 19, 1948, to May 1, 1948
 and that I last saw him alive on May 1, 1948
 Immediate cause of death.....Pneumonia
 DURATION.....

Due to.....Leak in wound
 in lower abdominal
 CO. Obstructive Cancer
 Di. conditions.....Recto Sigmoid Colon
 (Include pregnancy within 3 months of death)
 Main findings of operation.....Annular Cancerous
 Recto Sigmoid Obstructive
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

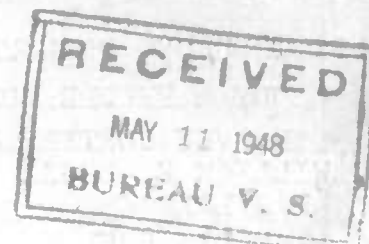
Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE.....A. H. Hawkins
 M. D. or other
 Address.....Circleville, Ohio Date signed.....May 2, 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04524

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany County
City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 13 years
Hospital, institution, or street address where death occurred:
829 Braddock Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 829 Braddock Rd
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. LeOra Marian Eggleston

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white married6. (b) Name of husband or wife Alan F. Eggleston7. Birth date of deceased (mo., day, yr.) 8/29/1879
6. (c) If alive, give age 69 years8. AGE: Years Months Days If less than one day
68 8 29 hrs. min.9. Birthplace Fond-du-lac, Wisconsin
(Town, county, and state)10. Usual occupation housewife

11. Industry or business

12. Name Orin Lee Helmer13. Birthplace Steete, N.Y.14. Maiden name LeOra Childs15. Birthplace Tuxton, Portland County, N.Y.16. Informant Alan F. EgglestonAddress 829 Braddock Road, Cumberland17. Burial Date thereof 6/1/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cemetery (Rose Hill)Location Fayette Street, Cumberland, Md.18. Funeral director John E. WolfordAddress 125 S. Liberty St.19. June 1 19 48 W. J. Fawcett, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 19 48 at 10³⁰ A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 19 46 to May 28 19 48
and that I last saw him alive on May 26 19 48Immediate cause of death Parkinson's Disease DURATION 5 yrs.

Due to

Due to

Other conditions Carcinoma Cervix 1 yr.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard W. Treviske, Jr. M.D. M. D. or otherAddress Cumberland, Md. Date signed May 25 '48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County... **Allegany**
 City or town... **Frostburg**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **All her life**
 Hospital, institution, or street address where death occurred:
Miners hospital
 How long in hospital or institution? **4 days**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State... **Maryland** County... **Allegany**
 City or town... **Frostburg**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... **61 W. Main St.**
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

CORA H. EVANS

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Horace Evans

7. Birth date of deceased (mo., day, yr.)

March 21, 1872

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

76

1

22

hrs.

min.

9. Birthplace

Frostburg, Allegany, Maryland
(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

home

FATHER
MOTHER

12. Name

George Hosken,

13. Birthplace

England

14. Maiden name

Hannah Kear,

15. Birthplace

England

16. Informant

Address

Stella Hosken,

Frostburg, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

May 15, 1948
(month) (day) (year)

Cemetery or crematory

Allegany Cemetery,

Location

Frostburg, Md.

18. Funeral director

Address

J. R. Durst,

Frostburg, Md.

19. 5-15

(Date rec'd by registrar)

19

48 Mrs. Nancy N. Roe
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 13, 1948, at 1:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 13, 1948, to May 13, 1948,
and that I last saw her alive on May 13, 1948.

Immediate cause of death

Cerebral Embolism

DURATION

3 wks.

Due to

Carcinoma of bladder

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. D. Latties M.D.

M. D. or other

Address

Frostburg Md.

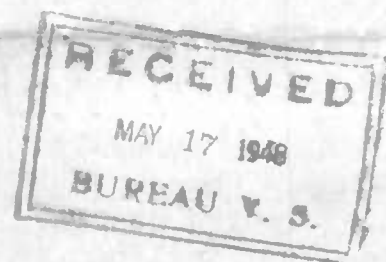
Date signed 5/14/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04526

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? about 3 min.Hospital, institution, or street address where death occurred:
On kitchen floor, 516 Necessity St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 528 N. Mechanic St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Robert Earl Fey

3. (b) Social Security Number

381-05-1051

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White married6. (b) Name of husband or wife Bertha Nee7. Birth date of deceased (mo., day, yr.) Dec. 29- 1887

8. AGE: Years Months Days If less than one day

60 4 17 hrs. min.9. Birthplace Cumberland Md.
(Town, county, and state)10. Usual occupation Peter Pan cleaners.

11. Industry or business

12. Name John T. Fey13. Birthplace Cumberland Md.14. Maiden name Jennie Wilkinson15. Birthplace Fredrick Md.16. Informant Dr. E. FayAddress Baltimore Pike, Cumberland Maryland17. Funeral Date thereof May 19 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Cumberland Maryland18. Funeral director Louis Stein, Inc.Address Cumberland Maryland19. May 19 1948 W. K. Trautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

about20. DATE OF DEATH May 16 1948 at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him Dead May 16 1948

Immediate cause of death

Coronary occlusion at onceDue to Coronary sclerosis

Due to

Other conditions Hypertention 2 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner Allegany Co.23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. ExaminerAddress Cumberland Md. Date signed 5-17-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 25 1948
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04527

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Sylvan Retreat
How long in hospital or institution? 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

John R. Fulk

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Unknown

6. (b) Name of husband or wife _____

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age _____ years

8. AGE:

92

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

Virginia

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. June 4, 1948

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 19 48 at 7:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 1946 to May 30 19 48and that I last saw him alive on May 28 19 48

Immediate cause of death

Myocardial failure

Due to

Chronic myocarditis

Due to

Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

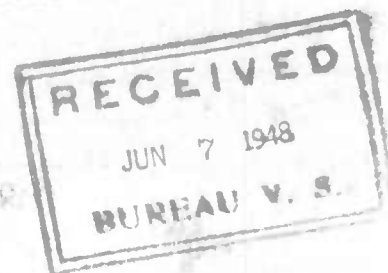
Means of injury

Injured at work?

23. SIGNATURE

Arthur F. Jones M.D.
M. D. or other _____
Address 110 S. Centre St. Date signed 6-4-48

1898
26
8561



DR. R. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04528

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... ALLEGANY

City or town... CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 DAYS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... ALLEGANY

City or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 432 WALNUT STREET
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (a) FULL NAME

MRS. LYDIA GARNER

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FEMALE WHITE WIDOWED

6. (b) Name of husband or wife... BERT B. GARNER

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) AUGUST 18, 1875

8. AGE: Years Months Days If less than one day
72 9 5 hrs. min.9. Birthplace... WEST VIRGINIA
(Town, county, and state)

10. Usual occupation... HWEE

11. Industry or business

12. Name... SAMUEL SISLER

13. Birthplace... WEST VIRGINIA

14. Maiden name... NANCY HAYES

15. Birthplace... WEST VIRGINIA

16. Informant... MEMORIAL HOSPITAL

Address... CUMBERLAND, MARYLAND

17. Burial... Date thereof... May 26, 48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Terra Alta.

Location... Terra Alta. W. Va.

18. Funeral director... A. F. Collins

Address... Terra Alta. W. Va.

19. May 25, 1948 W. H. Trautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... MAY 23, 1948, at 7:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/22/48 to 5/23/48 and that I last saw him alive on 5/23/48

Immediate cause of death... Cerebral Hemorrhage

Due to... Hypertension

Due to... Arteriosclerosis

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... M. D. or other

Address... Date signed... 5/24/48

RECEIVED

JUN 2 1948

BUREAU V. S.

DR. GRACIE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04529

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town ROUTE #1, OAKLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MARTHA GEORGE

3. (b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

MARCH 3, 1947

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

1

2

10

hrs.

min.

9. Birthplace

MARYLAND

(Town, county, and state)

10. Usual occupation

Child

11. Industry or business

FATHER
MOTHER

12. Name

WILLIAM GEORGE

13. Birthplace

WEST VIRGINIA

14. Maiden name

UNA REAMS

15. Birthplace

WEST VIRGINIA

16. Informant

MEMORIAL HOSPITAL

Address

MEMORIAL AVE., CUMBERLAND, MD.

17.

Burial

Date thereof

May 15, 1948

(Burial, cremation, or removal. Which?)

Cemetery or crematorium

Taylor Street Cem.

Location

Rt. #1, Oakland, Md.

18. Funeral director

Emory Bolden

Address

Oakland, Md.

19.

May 14, 1948 W.R. Tantz, M.D.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 13, 1948 19 at 2:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 11, 1948, to May 13, 1948

and that I last saw him alive on May 12, 1948

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/11/48

Where did injury occur? Garrett Co. Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of Injury Upset & fell off bed while injured at work?

23. SIGNATURE

W.R. Tantz, M.D.

M. D. or other

Address Cumberland, Md. Date signed May 13-48

MARGIN RESERVED FOR BINDING

VS 415 9-45-15M

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

04530

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year
 Hospital, institution, or street address where death occurred
75 Armstrong St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Allegany
 City or town P.O. Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 75 Armstrong St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Alice Caroline Tracy

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Robert Tracy

7. Birth date of deceased (mo., day, yr.) Feb. 20 - 1863 6. (c) If alive, give age 85 years

8. AGE: Years 85 Months 3 Days 3 If less than one day hrs. min.

9. Birthplace Oakwood, Paulding, Ohio
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name Fuller

15. Birthplace Oakwood, Paulding Co. Md.

16. Informant Mrs. Wm. Spence

Address 75 Armstrong St. Frostburg

17. Burial Date thereof 5-25-1948
 (Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director Joseph Trafer

Address Frostburg, Md.

19. 5-28- 19 48 Dr. Nancy & Rae
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 19 48 at 2:00 P. M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Apr 1 19 48 to May 23 19 48

and that I last saw her alive on May 21 19 48

Immediate cause of death Chronic myocarditis DURATION 7

Due to Semility

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

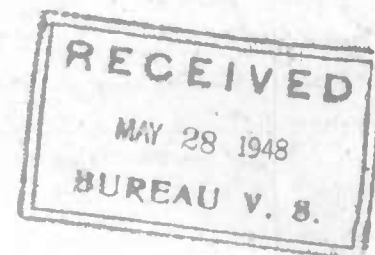
23. SIGNATURE WOM Lane MD M. D. or other

Address Frostburg Md Date signed 5-24-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 days
 Hospital, institution, or street address where death occurred:
Allegheny Hospital
 How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegheny
 City or town Westonport
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 109 Front St
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

David Barry Grandstaff

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) May 18 1948
 8. AGE: Years - Months - Days 2 if less than one day
hrs. min.

9. Birthplace Cumberland, Allegheny, Md
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name Barry Grandstaff13. Birthplace Frederick, W. Va14. Maiden name Katherine Montgomery15. Birthplace Bergh W. Va16. Informant Barry GrandstaffAddress Westonport, Md17. Burial Date thereof May 21, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Peter CemeteryLocation Westonport, Md18. Funeral director Ellsworth A BoalAddress Westonport, Md19. May 21 19 48 W. J. Tautz, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 19 48 at 4:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
18 May 19 48 to 20 May 19 48
 and that I last saw him alive on 20 May 19 48

Immediate cause of death Congenital Abnormalities
PT. Lung

Due to.....

Due to.....

Other conditions Upper SpinalSpinal Cord - Sacral

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ellsworth A BoalAddress 1123 2nd St M. D. or otherDate signed 20 May 48

POSTAL TELEGRAPH

RECEIVED
MAY 25 1943
BUREAU V. 3.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04532

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

City Hall, N.Center St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 207 Piedmont Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Samuel E. Griminger

3. (b) Social Security Number

220-16-6229

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white married6. (b) Name of husband or wife Edith Thum7. Birth date of deceased (mo., day, yr.) Sept 8, 1884

8. AGE: Years Months Days If less than one day

63 7 26 hrs. min.9. Birthplace Cumberland, Md.
(Town, county, and state)10. Usual occupation City Clerk11. Industry or business Cumberland, Md.12. Name Samuel Griminger13. Birthplace Maryland14. Maiden name Manley15. Birthplace Maryland16. Informant Edith T. GrimingerAddress 207 Piedmont Ave Cumberland17. burial Date thereof May 7, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hillcrest Burial ParkLocation Cumberland Md18. Funeral director Louis Stein, Inc.Address Cumberland Md.19. May 5, 48 W.R. Tautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 19 48 at 3:25 p m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him in Dead May 4 19 48

Immediate cause of death

Coronary occlusion

DURATION

about
6 Mo.Due to Coronary sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

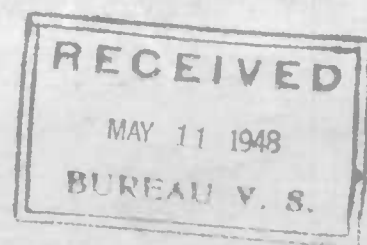
Means of injury Injured at work?

Deputy Medical Examiner Allegany Co23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. DemingAddress Cumberland Md. Date signed 5-4-48

MARGIN RESERVED FOR BINDING

VS A151 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

04533

CERTIFICATE OF DEATH

Reg. Dist. No. 5

1. PLACE OF DEATH:

County Allegheny
 City or town Amesville, near Cresaptown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Rt 5 Cumberland, Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegheny
 City or town Cresaptown, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Rt 5 Cumberland, Md.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

James Henry Gunning

3. (b) Social Security Number

None

4. Sex Male 5. Color of face White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Lillie Steinitz Gunning
 7. Birth date of deceased (mo., day, yr.) June 14 1882
 8. AGE: Years 65 Months 10 Days 20 If less than one day
 hrs. min.

9. Birthplace Cresaptown, Allegheny Co. Md
(Town, county, and state)10. Usual occupation Salvage11. Industry or business Farm12. Name J. B. Gunning by adoption13. Birthplace Eickhart, Pa.14. Maiden name Mary Hughes by adoption15. Birthplace Bedford Pa.16. Informant Mrs. Beltrand EasonAddress Rt 5 Cumberland, Md.17. Burial Date thereof May 7, 1948
(Burial, cremation, or removal. Where?)Cemetery or crematory St. Peter & Paul's Catholic Cem.Location Cumberland Md.18. Funeral director John J. HagerAddress Cumberland Md.19. May 7 48 M. D. Van Meter
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 19 48 at 3:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 19 48 to May 4 19 48and that I last saw him alive on May 4 19 48Immediate cause of death Acute Congestive Heart Failure

DURATION

12 hoursDue to Chronic myocarditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. J. McFarland M. D. or otherAddress Cresaptown Md. Date signed 5-6-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04534

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 Yrs

Hospital, institution, or street address where death occurred:

3 Fayette St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 3 Fayette St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William H Hall

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife

Manda Brown7. Birth date of deceased (mo., day, yr.) 5/31/1862

8. AGE: Years Months Days If less than one day

86 0 0 hrs. min.9. Birthplace Cumberland, Maryland
(Town, county, and state)10. Usual occupation Janitor - Retired

11. Industry or business

12. Name George Hall13. Birthplace Unknown14. Maiden name Minerva Brown15. Birthplace Unknown16. Informant Virginia WilliamsAddress 13 Fayette St. Cumb. Md.17. Burial Date thereof June 2, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Sumner CemeteryLocation Cumberland, Md.18. Funeral director John C. StaffordAddress 105 S Liberty St. Cumberland, Md.19. Date rec'd by registrar June 2, 1948 W. L. Dautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1948 at 7:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 28, 1948 to May 31, 1948and that I last saw him alive on May 28, 1948

Immediate cause of death

Generalized arteriosclerosis. Hardening of

Due to

arteries

Due to

arteriesOther conditions Senility

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. M. Williams, M.D. M. D. or otherAddress 41 Grant St. Date signed June 1, 1948

MARGIN RESERVED FOR BINDING

9.45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04535

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 years
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 911 Brentwood Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Griffith B. Hansell

3. (b) Social Security Number

214-05-9230

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Myrtle Miller
 7. Birth date of deceased (mo., day, yr.) February 18, 1902 6. (c) If alive, give age 44 years
 8. AGE: Years 46 Months 2 Days 14 If less than one day _____ hrs. _____ min.

9. Birthplace West Virginia
 (Town, county, and state)
 10. Usual occupation Tinner for C. W. Davy
Cumberland, Md.
 11. Industry or business _____

12. Name Joseph Hansell
Maryland
 13. Birthplace
 14. Maiden name Jennie Jeffries
Maryland
 15. Birthplace

16. Informant Memorial Hospital
 Address Cumberland, Maryland

17. Burial Date thereof May 5, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Hillcrest Cemetery
 Location Cumberland, Md.

18. Funeral director John J. Hoff
 Address Cumberland, Md.

19. May 4 19 48 H. R. Marty, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 19 48 at 5:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 9 19 47 to May 2 19 48
 and that I last saw him alive on May 2 19 48

Immediate cause of death _____ DURATION _____
Cardiovascular
renal disease

Due to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations none Date of op. none

Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

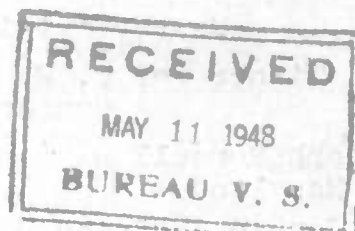
23. SIGNATURE F. Williams M. D. _____
Cumberland Date signed 5/3/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Within Dr. R. Durrett

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04536

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
 Locality Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 hours 13 minutes
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 13 hours 13 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State West Virginia County Mineral
 City or town Ridgeley
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 18 Johns Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war ✓

3. (a) FULL NAME

Baby Boy Hansrote

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife _____
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) May 16, 1948
 8. AGE: Years _____ Months _____ Days _____ If less than one day 13 hrs. 13 min.

9. Birthplace Cumberland, Allegany, Md.
 (Town, county, and state)
 10. Usual occupation Newborn infant
 11. Industry or business _____

12. Name Glen R. Hansrote
 13. Birthplace Maryland
 14. Maiden name Verna Ruth Lewis
 15. Birthplace West Virginia

16. Informant Memorial Hospital
 Address Cumberland, Maryland
 17. Burial Date thereof May 17, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetary or crematory Greenmount Cemetery
 Location Cumberland, Md
 18. Funeral director W. J. Hoff

Address Cumberland, Md
 19. May 17, 1948 W. D. Trautz, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1948 at 2:17 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 16, 1948 to May 16, 1948
 and that I last saw him alive on May 16, 1948

Immediate cause of death _____ DURATION 30 hrs
Premature

Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE W. D. Trautz M. D. or other W. D. Trautz
 Address Cumberland Date signed 5/17/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 yrs.
 Hospital, institution, or street address where death occurred:
601 Washington St.
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 601 Washington St
 (If rural, give LOCATION)
 2. (a) If veteran, name war -

3. (a) FULL NAME

R. Mason Hill

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

M

W

Married

6. (b) Name of husband or wife

Florence Reed

7. Birth date of deceased (mo., day, yr.)

December 22, 1871

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

76

5

8

hrs.

min.

9. Birthplace

Frostburg Maryland

(Town, county, and state)

10. Usual occupation

Clerk

11. Industry or business

Allegany County Court House

FATHER

12. Name

Thomas Hill

13. Birthplace

Ireland

14. Maiden name

Elizabeth Mason

15. Birthplace

Penn.

16. Informant

Florence Hill

Address

601 Washington St. Cumberland Md

17.

Burial, cremation, or removal. Which?

Date thereof

June 1, 1948
(month) (day) (year)

Cemetery or crematory

Allegany Cemetery

Location

Frostburg Maryland

18. Funeral director

Louis Stein Inc

Address

Cumberland Md

19.

June 1, 1948
(Date rec'd by registrar)W. J. Tautz, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30, 1948 at 1:10 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Jan 31, 1947 to 5-30-48and that I last saw him alive on 5-27-48Immediate cause of death Chronic MyocardialDue to degenerationDue to -Other conditions -

(Include pregnancy within months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?.....

23. SIGNATURE

W. J. Tautz
Cumberland Date signed 5/1/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mr. Stue



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04538

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 82 Yrs 11 Mo 4 Days
 Hospital, institution, or street address where death occurred:
226 Columbia St
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 226 Columbia St
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Ida May Hilleary

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Richard P. Hilleary
 7. Birth date of deceased (mo., day, yr.) June 18 1865 6. (c) If alive, give age 82 years
 8. AGE: Years 82 Months 11 Days 4 It less than one day _____ hrs. _____ min.
 9. Birthplace Cumberland, Allegany Co., Maryland
 (Town, county, and state)
 10. Usual occupation House
 11. Industry or business

MOTHER FATHER
 12. Name Casper Cassen
 13. Birthplace Germany
 14. Maiden name Elizabeth Bennett
 15. Birthplace Cumberland, Md.
 16. Informant Mrs Elizabeth Cassen
 Address 435 Columbia St, Cumberland, Md.
 17. Burial Date thereof 5/25/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Cumberland, Md.
 18. Funeral director William H. Kight
 Address Cumberland, Md.
 19. May 24 19 48 W. R. Trutz M.D.
 (Date rec'd by registry) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 19 48 at 5:15 p.m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17 19 48 to May 22 19 48
 and that I last saw him alive on May 22 19 48
 Immediate cause of death Acute myocardial infarction
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)
 Major findings of operations _____
 Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Charlotte B. Gardner M. D. or other _____
 Address Cumberland md Date signed 5-22-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 2 1948

BUREAU V. S.

DR. MCFARLAND

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

04539

1. PLACE OF DEATH:

County... ALLEGANY

City or town... CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 7

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MARYLAND County... ALLEGANY

City or town... CRESAPTOWN, MD.
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

MR. MAURICE E. HINDS

3. (b) Social Security Number

214-05-5529

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife BERTHA B. JOHNSTON

7. Birth date of deceased (mo., day, yr.)

JANUARY 23, 1889

6. (c) If alive, give age 57 years

8. AGE: Years Months Days If less than one day

59

3

14 20

hrs.

min.

9. Birthplace... WEST VIRGINIA
(Town, county, and state)

10. Usual occupation... BLOCK # 3

11. Industry or business CELANESE CORP. OF AMERICA

12. Name MR. JOHN F. HINDS

13. Birthplace WEST VIRGINIA

14. Maiden name IDA MECHEM

15. Birthplace MARYLAND

16. Informant... MEMORIAL HOSPITAL

Address MEMORIAL AVE., CITY

17. Burial Date thereof May 10, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenway Cemetery

Location Berkeley Springs, W. Va.

18. Funeral director... J. F. Hoff

Address Cumberland, Md.

19. May 8, 1948 W. H. Taub, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... MAY 7, 1948 at 1:10 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

May 4, 1948 to May 6, 1948

and that I last saw him alive on May 6, 1948

Immediate cause of death

Myocardial infarction

Due to post-operative

gastroenteritis

Due to peritonitis

and cholecystitis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. F. Hoff M. D. or other

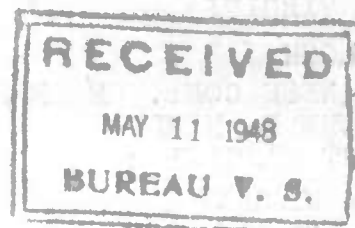
Address Date signed 6/7/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

634 Columbia Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 634 Columbia Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lilley May Horchler

3. (b) Social Security Number

None

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife John Horchler6.(c) If alive, give age 62 years

7. Birth date of

deceased (mo., day, yr.)

Oct. 18-18861885

8. AGE:

Years

Months

Days

If less than one day

6275

hrs.

min.

9. Birthplace Twiggstown Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
MOTHER12. Name John Wilmont13. Birthplace Md.14. Maiden name Niama Twigg15. Birthplace Md.16. Informant John H. HorchlerAddress Cumberland Md.Burial17. Date thereof May 25 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Rose Hill Cem.Location Cumberland, Md.18. Funeral director Louis Stein Inc.Address Cumberland, Md.19. May 24 19 48
(Date rec'd by registrar)W.R. Taubert, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 19 48 at 3:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 48 to 19 48and that I last saw him/her alive on May 23 19 48

Immediate cause of death

Chronic myocarditis

DURATION

about2 yrs.

Due to

Due to

Other conditions Hypertention & edema of lower legs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Deputy Medical Examiner Allegany23. SIGNATURE H.V. Deming M.D. otherAddress Cumberland Md. Date signed 5-23-48

RECEIVED

JUN 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Reeves 04541

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany
 City or town Barton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 60 years
 Hospital, institution, or street address where death occurred:
State Road
 How long in hospital or institution? - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Alleagny
 City or town Barton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. State Road
 (If rural, give LOCATION)
 2. (a) If veteran, name war - - - - -

3. (a) FULL NAME

SARAH ANN HYDE

3. (b) Social Security Number

- - - - -

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife William Hyde, Sr
 7. Birth date of deceased (mo., day, yr.) October 6, 1870
 6. (c) If alive, give age - - - years
 8. AGE: Years 77 Months 7 Days 3 If less than one day - hrs. - min.

9. Birthplace Lonaconing, Alleghany, Maryland
 (Town, county, and state)
 10. Usual occupation Domestic
 11. Industry or business Own home
 12. Name William KirkPatrick
 13. Birthplace Scotland
 14. Maiden name Janette Cleland
 15. Birthplace Scotland

16. Informant Mr Chester Hyde
 Address Barton, Maryland
 17. Burial Date thereof May 11, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Laurel Hill Cemetery
 Location Moscow, Maryland
 18. Funeral director Ellsworth S. Boal
 Address Westernport, Md.

19. May 11 19 48 Westernport Md
 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9, 1948 19 48 at 6:00p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 48 to May 9 19 48
 and that I last saw him alive on May 6 19 48

Immediate cause of death
Chronic Myocarditis
Chronic gall bladder disease
 DURATION
1 yr.
6 mo

Due to - - - - -Due to - - - - -Other conditions - - - - -

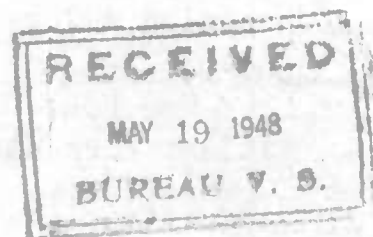
(Include pregnancy within 3 months of death)

Major findings of operations - - - - -Date of op. - - - - -Autopsy results - - - - -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - - - - - Date of - - - - -Where did injury occur? - - - - - (City or town) (County) (State)Injured at home, farm, industry, public place (where?) - - - - -Means of injury - - - - - Injured at work? - - - - -23. SIGNATURE Norman Reeves, Jr. M. D. or otherAddress Westernport Md Date signed 5/10/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04542

CERTIFICATE OF DEATH

Reg. Dist. No. 7

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Algonquin Hotel, Washington St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. Algonquin Hotel, Washington St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Robert Jackson

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male

white

single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug. 12th 18808. AGE: Years Months Days If less than one day
67 8 21 hrs. min.9. Birthplace Lonaconing Md.
(Town, county, and state)10. Usual occupation Clerk of Allegany Circuit Court.

11. Industry or business

12. Name Thomas Jackson13. Birthplace Scotland14. Maiden name Janet Stevenson15. Birthplace Scotland16. Informant Helen JacksonAddress Washington, D. C.17. Burial Date thereof May 6 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak Hill CemeteryLocation Lonaconing, Md.18. Funeral director M. EichhornAddress Lonaconing, Md.19. May 5 1948 W. R. Haatz, M.D.
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION about

20. DATE OF DEATH May 3 19 48 at 2 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19 48 at 2 A. M
and that I last saw h. im Dead May 3 19 48Immediate cause of death Coronary occlusion DURATION at onceDue to coronary sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or otherAddress Cumberland Md. Date signed 5-3-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 11 1948

BUREAU V. S.

Evidence for change of
birth date shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04543

164c
HAM NO. G 116 JUN 10 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
79 Linden St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 79 Linden St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Harry Fredrick Johns

3. (b) Social Security Number

220-16-5836

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white married

6. (b) Name of husband or wife Ruth Fram Johns

7. Birth date of deceased (mo., day, yr.) Sept. 2-1906 1905

8. AGE: Years Months Days If less than one day

42 8mo 6 hrs. min.

9. Birthplace Borden Mines Md.
(Town, county, and state)

10. Usual occupation Engineering Dept.

11. Industry or business Celavere

12. Name John Johns

13. Birthplace Borden Mines Md.

14. Maiden name Annie Brode

15. Birthplace Frostburg Md.

16. Informant Mrs Ruth F. Johns

Address Frostburg Md.

17. Burial Date thereof May 31st. 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director Jacob Hafer

Address Frostburg, Md.

19. 5-31 19 48 Mrs. Nancy K. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 19 48, at 4.30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 48, to 19 48

and that I last saw him Dead May 28 19 48

Immediate cause of death Intracranial hemorrhage due to at
a self inflicted (12 gauge shot-once
**gun) wound in right orbital
region.

Due to

Other conditions Fractured bones, right
side of face & head.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 5-28-48

Where did injury occur? Frostburg Allegany Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury as above Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. Registrar

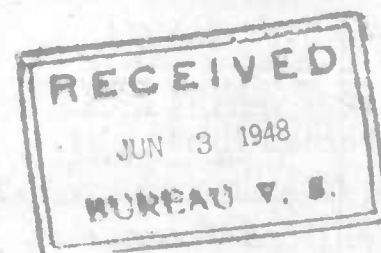
Address Cumberland Md. Date signed 5-29-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

04544

1. PLACE OF DEATH:

County Allegheny
 City or town Lansdowne, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 71 yrs.
 Hospital, institution, or street address where death occurred:
Dundley St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegheny
 City or town Lansdowne, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Dundley St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Daniel Jones

3. (b) Social Security Number

220-10-2657

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Clara Fagundabar Jones
 6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Feb. 24-1877

8. AGE: Years 71 Months 2 Days 10 If less than one day
hrs.min.

9. Birthplace Lansdowne Md.
 (Town, county, and state)

10. Usual occupation Janitor

11. Industry or business

12. Name Williams Jones

13. Birthplace Wales

14. Maiden name Rebecca Bradley

15. Birthplace Scotland

16. Informant Clara Fagundabar Jones (wife)

Address Lansdowne Md.

17. Burial Date thereof May 7, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegheny Cemetery

Location Frostburg, Md.

18. Funeral director Mr. H. S. Johnson

Address Lansdowne, Md.

19. 4/57 20. 48 Janette M. Boal
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1948 at 2:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him Dead May 4 1948

Immediate cause of death Coronary occlusion

Due to Coronary sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature H. V. Deming M.D. M. D. or other

Address Cumberland, Md. Date signed 5-4-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10

04545

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... Allegany
City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 Yrs 2 Mo 22 Days
Hospital, institution, or street address where death occurred:
323 Emily Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Allegany
City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 323 Emily Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME

William Bernard Kabosky

3.(b) Social Security Number

None

4. Sex Male	5. Color or race White	6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife		
7. Birth date of deceased (mo., day, yr.) February 15 1933		
8. AGE: Years 15	Months 2	Days 22
It less than one dayhrs.min.		

6.(c) If alive, give age years

9. Birthplace... Cumberland, Allegany Co., Md
(Town, county, and state)

10. Usual occupation... Student

11. Industry or business

12. Name... Thomas Kabosky
13. Birthplace... Cumberland, Md.
14. Maiden name... Marion ~~_____~~ Tagentaker
15. Birthplace... Cumberland, Md.

16. Informant... Mrs Marion Weimer
Address... 323 Emily St, Cumberland, Md.

17. Burial Date thereof... 5/10/48
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory... St Peter & Paul Cemetery
Location... Cumberland, Md.

18. Funeral director... William H. Kight
Address... Cumberland, Md.

19. May 10, 1948 W.R. Lantz, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 7 19... 48 at 5-30P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Apr. 28, 1948 to May 7, 1948
and that I last saw him alive on May 7, 1948

Immediate cause of death... Diphtheria

DURATION

2 wks.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... May 8, 1948 W.R. Lantz, Md. M. D. or other

Address... Cumberland Date signed... 5/7/48

RECEIVED

MAY 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04546

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 2 hrs & 25 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNA. County BEDFORDCity or town HYNDMAN
(If outside city or town limits, write RURAL and give nearest town)Street No. Route #1
(If rural, give LOCATION)2. (a) If veteran, name war ☒

3. (a) FULL NAME

ROY KENNEL

3. (b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED6. (b) Name of husband or wife NAOMA EBERICK7. Birth date of deceased (mo., day, yr.) August 24th 18918. AGE: Years 56 Months 8 Days 12 (If less than one day) hrs. min.9. Birthplace Penna. (Town, county, and state)10. Usual occupation SAW MILL WORKER

11. Industry or business

12. Name WILLIAM KENNEL13. Birthplace PENNA.14. Maiden name EFFIE LEPLY15. Birthplace PENNA.16. Informant Mrs. Naoma Eberick KennelAddress Hyndman, PA RFD #117. Burial Date thereof 5 11 48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Comp.Location Hyndman, P.F.H. #118. Funeral director Harvey H. LeiglerAddress Hyndman Pa.19. May 8 19 48 W. D. Tautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 19 48 at 1.35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive Dead May 6 19 48Immediate cause of death Severe cerebralcontusions and shockDURATION about 1 1/2 days

Due to

Due to

Other conditions Fracture of pubic bone andleft femur

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5-4-48Where did injury occur? Near Hyndman Bedford Pa
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) On mountainMeans of injury Ran over by a truck Injured at work? 5-4/48Deputy Medical Examiner Allegany23. SIGNATURE H.V. Deming M.D. H.V. Deming Md
M. D. or otherAddress Cumberland Md. Date signed 5-6-48

RECEIVED
MAY 11 1948
BUREAU V. S.

STANDARD CERTIFICATE OF DEATH

State File No. 04547Registrar's No. 1316State of Maryland

1. PLACE OF DEATH:

(a) County Allegany
(b) City or town Rural near Dawson
(If outside city or town limits, write RURAL)
(c) Name of hospital or institution:
R#3 Keyser, W. Va.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community 6 years
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Allegany
(c) City or town Rural near Dawson
(If outside city or town limits, write RURAL)
(d) Street No. (R#3 Keyser, W. Va.)
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) FULL NAME Lora Childress Kesner3. (b) If veteran, name war no 3. (c) Social Security No. no

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, divorced widow
(b) Name of husband or wife James Cecil Kesner 6. (c) Age of husband or wife if alive died 1937
7. Birth date of deceased July 11th 1877
(Month) (Day) (Year)

8. AGE: Years 70 Months 9 Days 20 If less than one day
hr. min.

9. Birthplace Pendleton Co., W. Va.
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business housewife12. Name John Adam Harper13. Birthplace Va.
(City, town, or county) (State or foreign country)14. Maiden name Suzanna Baker15. Birthplace Va.
(City, town, or county) (State or foreign country)16. (a) Informant's own signature Miss Hazel Kesner(b) Address R#3, Keyser, W. Va.17. (a) Burial (b) Date thereof May 4 48
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place; burial or cremation Dawson CemeteryDawson, Md.18. (a) Signature of funeral director Rogers Funeral Home(b) Address Keyser, W. Va.19. (a) May 4, 1948 (b) Harper
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. Date of death: Month May day 1st
year 1948 hour 2.45 p.m. minute _____21. I hereby certify that I attended the deceased from Aug 1
1947, to April 28, 1948:
that I last saw her alive on April 28, 1948:
and that death occurred on the date and hour stated above.Immediate cause of death Pulmonary edema Duration 6 daysDue to myocarditis with degenerationDue to nephritis chronicOther conditions _____
(Include pregnancy within 3 months of death)Major findings: _____
Of operations noOf autopsy no

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature W. B. Harper (M. D. or other) _____Address Keyser, W. Va. Date signed 7/24/48

STANDARD CERTIFICATE OF DEATH

State of Michigan

City of Detroit

County of Wayne

Decedent's Name

Age

Sex

Color

Marital Status

Occupation

Place of Birth

Date of Death

Time of Death

Place of Death

Cause of Death

Manner of Death

Signature of Physician

Signature of Coroner

Signature of Registrar

RECEIVED

MAY 5 1948

BUREAU V. S.

1

1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

05498

DR. JACOBSON

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY
 City or town CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 HOUR 45 years
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution? 1 HOUR

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY
 City or town CUMBERLAND
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 882 Gephart Drive
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

MR. FLOYD E. KUNES, SR.

3. (b) Social Security Number

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWED
 6.(b) Name of husband or wife MRS. ESTELLA THOMAS
 7. Birth date of deceased (mo., day, yr.) JANUARY 21, 1878 6.(c) If alive, give age years
 8. AGE: Years 70 Months 3 Days 20 If less than one day hrs. min.

9. Birthplace LANCASTER COUNTY, PENNA.
 (Town, county, and state)
 10. Usual occupation RETIRED B & O ENGINEER
 11. Industry or business

12. Name WM. HENRY KUNES
 13. Birthplace PENNA.
 14. Maiden name ELLEN D'LONG
 15. Birthplace PENNA.

16. Informant Mrs. William Donaldson
 Address Lavale, Cumberland, Md.
 17. Burial Date thereof May 13, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hyndman Cemetery
 Location Hyndman, Pa.
 18. Funeral director John J. Weber
 Address Cumberland, Md.

19. May 13 19 48 W.R. Krantz, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 11 19 48 at 1:55 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 19 48 to May 11 19 48
 and that I last saw him alive on May 10 19 48

Immediate cause of death Cerebral Hemorrhage DURATION 6 hours

Due to Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Samuel Donaldson M. D. or otherAddress 50 Peshway St Date signed 5/11/48

RECEIVED

MAY 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04548

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany
 City or town Dansville Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany
 City or town Dansville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Mrs. Carrie (John) Lancaster

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife John Lancaster
 6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) March 30-1894
 8. AGE: Years 54 Months 1 Days 26 If less than one day _____ hrs. _____ min.

9. Birthplace Barton Md. Allegany, Md.
 (Town, county, and state)

10. Usual occupation housewife

11. Industry or business own home

12. Name Lee Ross

13. Birthplace Barton Md.

14. Maiden name Ester Klipstein

15. Birthplace Barton Md.

16. Informant John Lancaster

Address Dansville Md.

17. Burial Date thereof May 30, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Waxler Cemetery

Location Dansville, Md.

18. Funeral director Ellsworth S. Boal

Address Westernport, Md.

19. May 28 19 48 W. H. Deming M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

about

20. DATE OF DEATH May 26 19 48 at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____, to _____ 19 _____, and that I last saw h. er Dead May 26 19 48.

Immediate cause of death Chronic myocarditis DURATION 10 yrs.

Due to _____

Due to _____

Other conditions Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

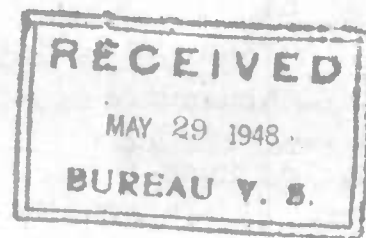
Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? Allegany Co.
Deputy Medical Examiner

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
 M. D. or other _____

Address Cumberland Md. Date signed 5-26-48



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 years

Hospital, institution, or street address where death occurred:

131 Cumberland Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 131 Cumberland Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

AMBROSE LAWRENCE

3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Mary A. (Harper) Lawrence6.(c) If alive, give age 79 years7. Birth date of deceased (mo., day, yr.) February 13, 18628. AGE: Years 86 Months 3 Days 18 If less than one day _____ hrs. _____ min.9. Birthplace Riverton, Pendleton, West Virginia
(Town, county, and state)10. Usual occupation Conductor (Retired)11. Industry or business W.M. Railroad12. Name Joshua Lawrence13. Birthplace Pendleton Co. W. Va.14. Maiden name Katherine Phares15. Birthplace Pendleton Co. W. Va.16. Informant Mrs. Nela G. WoodAddress 131 Cumberland St. Cumberland, Md.17. Burial Date thereof June 2, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hill Crest Burial ParkLocation Cumberland, Maryland18. Funeral director William H. KightAddress Cumberland, Md.19. June 2 19 48 W.H. Kight, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 19 48 at 9:40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 10 19 48 to May 30 19 48and that I last saw him alive on May 30 19 48

Immediate cause of death

Anterior sclerosis

DURATION

Due to Familial

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.H. Kight, M.D. M. D. or otherAddress 49 Meene St Date signed 6-2-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 7 1948
BUREAU V. S.

K94x

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04550

DR. HAWKINS

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND MARYLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 19 DAYS & 4 HOURS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 19 DAYS & 4 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County GARRETTCity or town DEER PARK
(If outside city or town limits, write RURAL and give nearest town)Street No. RT# 2

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MRS. IDA LEE

4. Sex

FEMALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

MARRIED6.(b) Name of husband or wife ROBERT H. LEERT# DEER PARK, MD

7. Birth date of

deceased (mo., day, yr.) OCTOBER 30, 18896.(c) If alive, give age 61 years

8. AGE:

Years

Months

Days

If less than one day

5861

hrs.

min.

9. Birthplace PENNA

(Town, county, and state)

10. Usual occupation WIFE

11. Industry or business

FATHER

12. Name JEREMIAH UPHOLD13. Birthplace Unknown

MOTHER

14. Maiden name LUCY COLLINS15. Birthplace Pennsylvania16. Informant Memorial HospitalAddress Cumberland, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 4, 1948
(month) (day) (year)Cemetery or crematory Pleasant Valley CemeteryLocation Esperet Co., Md.18. Funeral director Herbert C. ReightonAddress Cakeland, Md.19. May 3, 1948

(Date rec'd by registrar)

19. 48W.R. Trout, M.D.
Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1948 at 4:50 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 12, 1948 to May 1, 1948and that I last saw him May 1, 1948Immediate cause of death Obstructive DURATIONCarcinoma sigmoid colonCaecostomyDue to Thrombophlebitis veinsDue to of legOther conditions Obstruction movingSwelling of Colon

(Include pregnancy within 3 months of death)

Major findings of operations Obstructive Carcinoma sigmoidDate of op. Apr. 27-48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

W.R. Trout M. D. or otherAddress Cumtland Md Date signed 5-1-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS 45

PLEASE WRITE PLAINLY, IN INK, UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 11 1948

BUREAU V. S.

Without corporate limited

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04551

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 years
 Hospital, institution, or street address where death occurred:
706 Lafayette Ave
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 706 Lafayette Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mary Rhodes Logsdon

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife John Logsdon
 6.(c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) May 23, 1861
 8. AGE: Years 86 Months 11 Days 11 If less than one day
 hrs. min.

9. Birthplace Spring Gap, Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own home
 12. Name Leonard Huff
 13. Birthplace Maryland
 14. Maiden name Elizabeth Davis
 15. Birthplace Spring Gap, Md.
 16. Informant Mrs. Lucy Mull
 Address 424 Goethe St, Cumberland Md.
 17. Burial Date thereof May 6, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Hillcrest Cemetery
 Location Cumberland, Md.
 18. Funeral director John J. Hoffer
 Address Cumberland, Md.
 19. May 6, 1948 W. H. Trautz, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 19 48 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 48 to May 4 19 48
 and that I last saw him alive on May 3 19 48

Immediate cause of death Cardio-renal disease DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. Bailey Hunter M. D. or otherAddress Cumberland Md. Date signed 5/4/48

RECEIVED
MAY 11, 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04552

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 years
 Hospital, institution, or street address where death occurred:
421 Independence St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 421 Independence St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Anna Viola Lowery

3. (b) Social Security Number

None

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced divorced
 6. (b) Name of husband or wife Robert Creighton
 7. Birth date of deceased (mo., day, yr.) Oct. 4, 1892
 8. AGE: Years 55 Months 7 Days 19 It less than one day hrs. min.

9. Birthplace Ellerslie, Md. Allegany, Maryland
 (Town, county, and state)
 10. Usual occupation housekeeper
 11. Industry or business

FATHER 12. Name Samuel Thomas Lowery
 13. Birthplace Ellerslie Md.
 MOTHER 14. Maiden name Alcinda Yost
 15. Birthplace Ellerslie, Md.

16. Informant Mrs. Harry Gilpin, Jr.
 Address Cumberland, Md.
 17. Burial Date thereof May 27, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Luke's Cemetery
 Location Cumberland, Maryland

18. Funeral director William H. Kight
 Address Cumberland, Md.

19. May 26, 1948 W. F. Tautz, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH May 23 19 48 at 3 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
 and that I last saw her alive Dead May 24 19 48

Immediate cause of death Coronary occlusion DURATION at once

Due to Coronary sclerosis about 1 yr.

Due to

Other conditions Diabetic.

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
 M. D. or other

Cumberland Md. Date signed 5.24-48

RECEIVED

JUN 2 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04553

Reg. Dist. No. 1

1. PLACE OF DEATH:

County Allegany
City or town Rural) near Picardy Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 1 week
Hospital, institution, or street address where death occurred:
house on Miller Farm, near route 51
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany
City or town Rural) near Picardy Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. P.O., R.F.D. 1 Paw Paw W. Va.
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Jess McKenzie

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced divorced
6. (b) Name of husband or wife Cora Nelson

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb. 29-1884

8. AGE: Years 64 Months 2 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Mineral Co. W. Va.
(Town, county, and state)

10. Usual occupation Laborer B. & O. R. Ry.

11. Industry or business

12. Name Mose McKenzie

13. Birthplace Mineral Co. W. Va.

14. Maiden name Mary M. Lark

15. Birthplace Mineral Co. W. Va.

16. Informant Mrs. Harry Butts

Address 443 Pennsylvania Ave.

17. Burial Date thereof May 29, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)
Greenmount Cem.

Cemetery or crematory

Location Cumberland, Md.

18. Funeral director James F. Scarpelli

Address Cumberland, Md.

19. May 28 1948 Mrs. A. Shanholz
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 19 48 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19 _____ to _____ 19 _____
and that I last saw him Dead May 26 19 48

Immediate cause of death Coronary occlusion DURATION at once

Due to Coronary sclerosis about 2
years

Due to

Other conditions hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. of _____

Address Cumberland Md. Date signed 5-27-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 2 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

04554

1. PLACE OF DEATH:

County alleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 19 daysHospital, institution, or street address where death occurred:
allegany county, homeHow long in hospital or institution? 1, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County alleganyCity or town Lanacoming
(If outside city or town limits, write RURAL and give nearest town)Street No. East main st
(If rural, give LOCATION)2.(a) If veteran, name war L

3. (a) FULL NAME

Mollie M. L. Larkie

3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Henry M. Larkie6. (c) If alive, give age 90 years7. Birth date of deceased (mo., day, yr.) Jan, 11th 18648. AGE: Years 84 Months 3 Days 24 If less than one day
hrs. min.9. Birthplace Lanacoming, allegany, md
(Town, county, and state)10. Usual occupation Home work11. Industry or business Own home12. Name Thomas13. Birthplace Wales14. Maiden name Mary E. Tarnent15. Birthplace England16. Informant Henry M. LarkieAddress Lanacoming, md17. Burial Date thereof May 8 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak Hill CemeteryLocation Lanacoming md18. Funeral director M. EichhornAddress Lanacoming, md19. May 8, 48 W.R. Nantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 19 48 at 11³⁰ A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Apr 6 19 48 to May 5 19 48
and that I last saw her alive on Apr 30 19 48

Immediate cause of death

Due to Myocardial failure
Chronic myocarditisDue to Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones M.D.
M. D. or otherAddress 110 S. Centre St. Date signed 5-5-48

RECEIVED

MAY 11 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

04555

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County... ALLEGANY
City or town... CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 DAYS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... MARYLAND County... ALLEGANY
City or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 216 BEALL ST.
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME
MINKE, MARY GERTRUDE MRS.
3. (b) Social Security Number
None

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced Divorced
6. (b) Name of husband or wife John E. Hocking (deceased)
7. Birth date of deceased (mo., day, yr.) February 2 1899 6. (c) If alive, give age..... years
8. AGE: Years 49 Months 3 Days 1 If less than one day..... hrs. min.

9. Birthplace... MD. Cumberland
(Town, county, and state)
10. Usual occupation... HWFE
11. Industry or business... HOME

12. Name... MINKE, HOHN, J.
13. Birthplace... MARYLAND
14. Maiden name... ROBINSON, AGNES CATHERINE
15. Birthplace... MARYLAND

16. Informant... John E. Hocking
Address... 322 Davidson St, Cumberland, Md.

17. Burial... May 7 1948
(Burial, cremation, or removal. Which?) Date the body was buried (month) (day) (year)
Cemetery or crematory... St Peter & Paul Cemetery
Location... Cumberland, Md.

18. Funeral director... William H. Kight
Address... Cumberland, Md.

19. May 6 19 48 W. R. Traub, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH... MAY 3, 1948 19... 3.00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 48 to May 3 19 48
and that I last saw him/her alive on May 3 19 48

Immediate cause of death... Coronary thrombosis
DURATION... 5 days

Due to.....
Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....
Means of injury..... Injured at work?

23. SIGNATURE... W. R. Traub M. D. or other...
Address... 104 W. 4th St. Date signed... 5/7/48

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The doctor's age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 11 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04556

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny Cumberland
City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

535 Columbia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 535 Columbia Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

John Morrissey

3. (b) Social Security Number

214-07-51224. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

(Unknown) 1873

6. (c) If alive, give age years

8. AGE:

Years 75

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Cumberland, Maryland
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Celanese Corp. of America

MOTHER

12. Name

Michael Morrissey

13. Birthplace

Ireland

14. Maiden name

Margaret Smer

15. Birthplace

Penna.

16. Informant

Louis Stein, Inc.

Address

Cumberland, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

May 12, 1948
(month) (day) (year)

Cemetery or crematory

Saint Patrick's Cem.

Location

Cumberland, Md.

18. Funeral director

Louis Stein, Inc.

Address

Cumberland, Maryland

19.

(Date rec'd by registrar)

May 11, 1948 W.R. Bantz, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 9, 1948 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 7, 1948 to May 9, 1948and that I last saw him alive on May 8, 1948

Immediate cause of death

Cerebral Hemorrhage

DURATION

2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. A. Treaskis, M.D.

M. D. or other

Address Cumberland, Md. Date signed May 10-48

RECEIVED

MAY 18 1948

BUREAU V. S.

When corporate limits DR. E. JONES

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

04557

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County ALEEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 DAYS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State PENN County BEDFORD
City or town EVERETT PA
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME ELIJAH FRANKLIN NELSON
3. (b) Social Security Number None

4. Sex MALE 5. Color or race WHITE 6.(a) Single, married, widowed, or divorced MARRIED

6.(b) Name of husband or wife BERTIE MALLOW
6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) FEB 17, 1880 1881
8. AGE: Years 67 Months 3 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace W. VA
(Town, county, and state)

10. Usual occupation FARMER

11. Industry or business _____

12. Name ELIJAH NELSON

13. Birthplace W. VA

14. Maiden name ELIZABETH THOMPSON

15. Birthplace W. VA

16. Informant MEMORIAL HOSPITAL

Address MEMORIAL HOSPITAL

17. Burial Date thereof May 31, 1948
(Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory Glendale Brothers Cem

Location Gas Port, Md.

18. Funeral director Jos. J. Balentine

Address Everett, Penna.

19. May 31, 1948 W. L. Frantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 29 19 48 at 6:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 May 19 48 to May 29 19 48
and that I last saw him alive on May 29 19 48

Immediate cause of death Uremia
Coronary Prostate Extension
to bladder

Due to Hydroxyphenol

Due to Hydroxyphenol

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

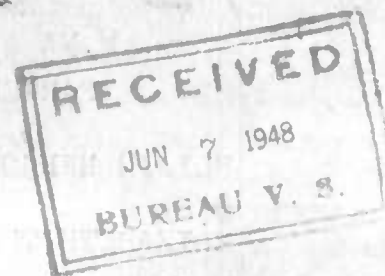
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE George M. Brown M. D. or other _____

Address Memorial Hospital Date signed 29 May 48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

96

04558

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital, Cumberland Md.

How long in hospital or institution? about 1 3/4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 324 N. Mechanic St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

William C. Nelson

3.(b) Social Security Number

234 - 30 - 1956

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white married

6.(b) Name of husband or wife Rozella Petenbrink

6.(c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) May 10-1924

8. AGE: Years Months Days If less than one day
24 0 2 hrs. min.

9. Birthplace Randolph Co. W.Va.
(Town, county, and state)

10. Usual occupation laborer

11. Industry or business Construction work

12. Name William Nelson (Foster) father

13. Birthplace W. Va.

14. Maiden name Ann Phares

15. Birthplace W. Va.

16. Informant Mrs. Rozella Nelson

Address 324 N. Mechanic ST., Cumberland Md.

17. Burial Date thereof 5/15/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenmount Cem.

Location Cumberland, Md.

18. Funeral director H. Wayne George

Address Cumberland, Md.

19. May 15, 1948 W.D. Traub, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1948 at 3.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him Dead May 12 1948

Immediate cause of death

Intracranial hemorrhage due to a rupture of a cerebral aneurysm, anterior to the circle of Willis.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.

Address Cumberland Md. Date signed 5.13-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04559

1. PLACE OF DEATH:

County Allegany County Memorial Hospital
City or town Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 15 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County HAMPSHIRE

City or town Romney, W. Va.
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

JOSEPH H. NEWHOUSE

3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Isabel Davis

7. Birth date of deceased (mo., day, yr.) June 30, 1864 6.(c) If alive, give age 78 years

8. AGE: Years 83 Months 10 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual occupation Mechanic

11. Industry or business Owner business

12. Name Newhouse

13. Birthplace W. Va.

14. Maiden name Rebecca Jane Earle

15. Birthplace Ireland

16. Informant Mrs Myrtle Tallant

Address Romney, W. Va.

17. Burial Date thereof May 15, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Indian Mound Cemetery

Location Romney, W. Va.

18. Funeral director Memph & Co

Address Romney, W. Va.

19. May 13 1948 Walter A. Brady M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1948 at 7:10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____

and that I last saw him in a DEAD May 13 1948

Immediate cause of death CARDIAC FAILURE at DURATION

DUE TO CORONARY SCLEROSIS, CARDIAC taminal

HYPERTROPHY AND PROSTATIC hypertrophy yes

Due to _____

Due to _____

Other conditions DISTENTION OF BLADDER

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

Deputy Medical Examiner = Allegany Co

23. SIGNATURE H. V. Deming M.D. M. D. or other

Address Cumberland Md Date signed 5/13/48

RECEIVED

MAY 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... Allegheny
 City or town... Westonport - rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 weeks
 Hospital, institution, or street address where death occurred:
R.F.O. #1 Box 9
 How long in hospital or institution? 2

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Allegheny
 City or town... Westonport - rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R7D#1 - Box 9
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

John James Pattison Jr.
 4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

3. (b) Social Security Number

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) April 9, 1948
 6.(c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
0 1 19 — hrs. — min.

9. Birthplace... Westonport, Allegheny, Maryland
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name... John James Pattison13. Birthplace... Westonport, Md14. Maiden name... Evelyn Louise Lambert15. Birthplace... Westonport, Md16. Informant... John J. PattisonAddress... Westonport, Md17. Burial Date thereof May 30, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Philos CemeteryLocation... Westonport, Md18. Funeral director... Elleworth I BoalAddress... Westonport, Md.19. May 28 1948 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... May 28 19 48 at 1 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw h... ER Dead May 28 19 48Immediate cause of death... AsphyxiationDue to... Asphyxiation of stomach contents

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegheny Co23. SIGNATURE... R. V. Drining M.D. M. D. or otherAddress... Cumberland Md Date signed... 5-28-48

RECEIVED

MAY 29 1943

BUREAU V. S.

Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04561

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

1105 Lexington Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 1105 Lexington Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Jennie Virginia Payton

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widow6.(b) Name of husband or wife Robert Payton6.(c) If alive, give age * years

7. Birth date of

deceased (mo., day, yr.)

March 19-1884

8. AGE:

Years

Months

Days

If less than one day

64128

hrs.

min.

9. Birthplace 21st. Bridge Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name George Washington House13. Birthplace Fredrick Md.14. Maiden name Susan M. Dayton15. Birthplace 21st. Bridge Md.16. Informant Mrs. Emma Hinrichs (sister)Address Mc Coole Md.17. Buried

(Burial, cremation, or removal. Which?)

Date thereof May 19, 1948
(month) (day) (year)Cemetery or crematory Dawson Cem.Location Dawson, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. May 18, 1948

(Date rec'd by registrar)

W. F. Frank M.D.
Registrar

3.(b) Social Security Number

None

MEDICAL CERTIFICATION

about20. DATE OF DEATH May 17 19 48 at 4 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....
and that I last saw him/her alive on May 17 19 48

Immediate cause of death

Uremia

DURATION

Due to Diabetes Mellitusseveral
years

Due to

Other conditions Partial paralysis of
the bowels following operation
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

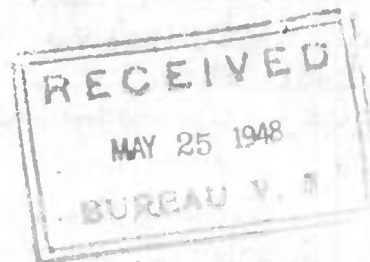
Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

Deputy Medical Examiner Allegany Co.23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. or otherAddress Cumberland Md. Date signed 5-17-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04562

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County alligany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 yrs.
 Hospital, institution, or street address where death occurred:
612 Washington
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County alligany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 612 Washington
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Nancy Allen Poling

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Samuel E. Poling
 5. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Feb. 9, 1873
 8. AGE: Years 75 Months 2 Days 15 If less than one day _____ hrs. _____ min.

9. Birthplace Tucker Co. West Va.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Francis G. Poling13. Birthplace West Va.14. Maiden name Lizzie J. Poling15. Birthplace West Va.16. Informant Carrie B. PolingAddress Cumberland Md.17. Burial Date thereof 5/6/1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Parson CemeLocation Parson M. Va.18. Funeral director Louis Stein Jr.Address Cumberland Md.19. May 6, 1948 W. H. Trautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4, 1948 at 9 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12, 1946 to May 4, 1948and that I last saw him alive on May 1, 1948Immediate cause of death chronic myocarditisDue to arteriosclerosis

Due to _____

Other conditions _____

(Include pregnancies within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

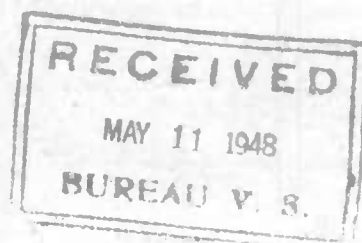
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE L. H. King M. D. or other _____Address 59 Queen St. Date signed 5-5-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04563

932

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
 City or town Eckhart Mines
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Eckhart Mines
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Margaret Catherine Porter

3. (b) Social Security Number

none

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Charles W. Porter

7. Birth date of deceased (mo., day, yr.)

April 10, 1861

6. (c) If alive, give age _____ years

8. AGE:

87

Years

0

Months

Days

25

If less than one day

hrs.

min.

9. Birthplace

Wellersburg Somerset, Pa.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home Beal

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

Date thereof

May 9, 1948

(Burial, cremation, or removal, which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. 5-9

Date rec'd by registrar

19. 48 Mr. Quincy N. Roe

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1948 at 2:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1943 1948 to May 6 1948and that I last saw her alive on May 3 1948

Immediate cause of death

Chronic myocarditis

DURATION

2 yrs

Due to

Similarity

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

WOM Lane MD

M. D. or other

Address

Frostburg MdDate signed 5-9-48

RECEIVED

MAY 12 1948

BUREAU V. S.

Within corporate limits.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

R. M. Schindler
04564

93d

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs.
Hospital, institution, or street address where death occurred:
Offutt Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. Offutt Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME James F. Rankin
3. (b) Social Security Number 705-09-5239

4. Sex M
5. Color or race W
6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Bessie Robinette

7. Birth date of deceased (mo., day, yr.) September 24, 1889
6. (c) If alive, give age years

8. AGE: Years 58 Months 8 Days 3 If less than one day hrs. min.

9. Birthplace Monticello, W. Va.
(Town, county, and state)

10. Usual occupation car repairman
11. Industry or business B. & O. R.R.

12. Name John Rankin
13. Birthplace W. Va.

14. Maiden name Anna Litten
15. Birthplace W. Va.

16. Informant Bessie Rankin
Address 1318 Virginia Ave. Cumberland Md

17. Burial Date thereof May 29, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Ross Hill Cemetery
Location Cumberland Md.

18. Funeral director Louis Stein, Inc.
Address Cumberland Md.

19. May 28, 1948 (Date rec'd by registrar)
W. H. Taub, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27, 1948 at 1:00 A.M.

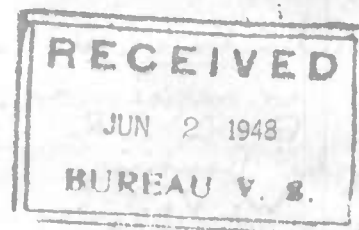
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1948 to May 27, 1948
and that I last saw him alive on May 23, 1948

Immediate cause of death
Coronary Arteriosclerosis
Due to Hypertensive C.V. Arteriosclerosis
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. M. Schindler
Address 41 Everett Date signed May 27, 1948
M.D. or other



2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1015 Virginia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 1015 Virginia Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Melvin Eugene Rankin

3. (b) Social Security Number

214-07-6741

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed or divorced

married6. (b) Name of husband or wife Naomi Silvious

7. Birth date of

deceased (mo., day, yr.)

May 28 19126. (c) If alive, give age 34 years

8. AGE:

Years

Months

Days

It less than one day

35115

hrs.

min.

9. Birthplace Cumberland Allegany Co Md
(Town, county, and state)

10. Usual occupation

Machinist

11. Industry or business

Celanece Corp.

MOTHER

FATHER

12. Name

Bluence W. Rankin

13. Birthplace

Sleepy Creek W. Va.

14. Maiden name

Mary C. Furlow

15. Birthplace

Thiggstown Md.

16. Informant

John D Rankin

Address

237 Bennett Ave - Cumberland Md

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

May 6, 1948

Cemetery or crematory

Rose Hill Cemetery

Location

Cumberland Md.

18. Funeral director

John J. Hager

Address

Cumberland Md.

19. (Date rec'd by registrar)

May 6, 1948

19. 48

W. L. Hartz, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

May 3

19. 48

at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 10 1948 to May 3 1948and that I last saw him alive on May 2 1948

Immediate cause of death

Rheumatic Heart Disease

DURATION

Years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B. M. Schindler M.D.

M. D. or other

Address

41 Everett St

Date signed

May 5/1948

RECEIVED

MAY 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

836 Dr Reeves 04566

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany
 City or town Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 34 years
 Hospital, institution, or street address where death occurred:
270 Main St
 How long in hospital or institution? - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 270 Main St
 (If rural, give LOCATION)
 2.(a) If veteran, name war - - - - -

3. (a) FULL NAME

JOSEPH PEARCE REED

3. (b) Social Security Number

- - - - -

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower
 6. (b) Name of husband or wife Mary Ellen Wilt Reed
 7. Birth date of deceased (mo., day, yr.) October 11, 1863
 6. (c) If alive, give age - - - years
 8. AGE: Years 84 Months 6 Days 27 If less than one day
 hrs. min.

9. Birthplace Elk Garden, Mineral, W. Va.
 (Town, county, and state)
 10. Usual occupation Carpenter (retired)
 11. Industry or business Building

FATHER 12. Name Alexander Reed
 13. Birthplace W. Va.
 MOTHER 14. Maiden name Sarah O'Haver
 15. Birthplace W. Va.

16. Informant W. B. Reed
 Address Westernport, Md.

17. Burial Date thereof May 11, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Bloomington Cemetery
 Location Bloomington, Md.
 18. Funeral director Ellsworth S. Boal
 Address Westernport, Maryland

19. May 11 19 48 Ellsworth S. Boal
 (Date registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 19 48 at 11:15p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 48, to May 8 19 48
 and that I last saw him alive on May 8 19 48

Immediate cause of death
Arteriosclerosis
Central thrombosis

DURATION
142
6 days

Due to
 Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Norman Reeves, M.D.
Westernport, Md. M. D. or other
 Address Date signed 5/10/48

RECEIVED

MAY 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years
 Hospital, institution, or street address where death occurred:
225 Baltimore Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 225 Baltimore Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Mary Cheney Robins

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Jasper W. Robins
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) September 9, 1857
 8. AGE: Years 90 Months 8 Days 16 It less than one day _____ hrs. _____ min.

9. Birthplace Murley's Branch, Allegany, Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own home
 12. Name Isaac Cheney
 13. Birthplace Murley's Branch
 14. Maiden name Henrietta Roberts
 15. Birthplace Allegany Co.

16. Informant Mrs. Homer D. Whip
 Address 225 Baltimore Ave, Cumberland, Md
 17. Burial Date thereof May 27, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Hillcrest Cemetery
 Location Cumberland, Md.
 18. Funeral director John J. Myers
 Address Cumberland, Md.
 19. May 27, 1948 W. H. Fautz, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1948 at 10:00 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 April 1948, to 25 May 1948.
 and that I last saw her alive on 25 May 48 1948.
 Immediate cause of death Cardiac Failure
 DURATION 2 months
 Due to Senility
 Due to Chronic Myocarditis 6/28/48
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Alan E. Grawshaw M.D.
Cumberland M. D. or other _____
220 Baltimore Ave Address _____ Date signed 25 May 48

RECEIVED

JUN 2 1948

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred:
Allegany County Infirmary
How long in hospital or institution? 3 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Allegany
City or town N. Mechanic St. Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. N. Mechanic St
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Mary Ruppert

3. (b) Social Security Number

None

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Frank Ruppert

7. Birth date of deceased (mo., day, yr.) March 19, 1862
6. (c) If alive, give age years

8. AGE: Years 86 Months 1 Days 12 If less than one day hrs. min.

9. Birthplace Cumberland Maryland
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name Henry Gendemen

13. Birthplace Md.

14. Maiden name Elizabeth S. Schellhaus

15. Birthplace Md.

16. Informant Richard Ruppert

Address Richdelan W. Va.

17. Buried Date thereof May 5, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Peter's & Paul's Cemetery

Location Cumberland, Md.

18. Funeral director Louis Stern, Inc.

Address Cumberland, Maryland

19. May 4, 1948 W. H. Dantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1948 at 5:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946 to May 1, 1948
and that I last saw her alive on Apr. 30, 1948

Immediate cause of death Myocardial failure

Due to Chronic Myocarditis

Due to Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones M.D.

Address 110 S. Centre St. Date signed 5-3-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 11 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 04569 5

1. PLACE OF DEATH:

County Allegany
 near Cumberland Md. (Amcelle)
 City or town (if outside city or town limits, write RURAL and give nearest town)

How long in above place of death? at once

Hospital, institution, or street address where death occurred:

Route 220 onroad in front of main
gate at Cellanese Corp. of Am.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 529 Green St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Friend
Mrs. Hazel Russ

3. (b) Social Security Number

220-03- 7622

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Walter Russ

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Jan. 27-1911

8. AGE:

Years

Months

Days

If less than one day

3736

hrs.

min.

9. Birthplace

Oakland Maryland
 (Town, county and state)

10. Usual occupation

Celanese Corp. of Am.

11. Industry or business

Rayon

FATHER

12. Name

Le Roy Friend

13. Birthplace

Maryland

MOTHER

14. Maiden name

Zeltha Knox

15. Birthplace

Maryland

16. Informant

Louis Stein, Inc.

Address

Cumberland, Md.

17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

May 5, 1948

Cemetery or crematory

Holmes and Biriel Park

Location

Cumberland Maryland

18. Funeral director

Louis Stein, Inc.

Address

Cumberland, Maryland

19.

(Date rec'd by registrar)

May 4, 1948M. O. M. M. M.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1948 at 10:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw her Dead May 3, 1948

Immediate cause of death

Subdural hemorrhage & shock

DURATION

at onceDue to hit by an Automobile

Walked in front of bus in path
of auto. going south.

Other conditions Fractured left leg above ankle
fracture at right wrist also 6, 7, 8 ribs
in right nipple line.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Auto accident Date of 5-3-48
Route 220 Amcelle
 Where did injury occur near Cumberland Allegany Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Highway, as above

Means of injury hit by auto. Injured at work? going to work

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
 M. D. or other

Address Cumberland Md. Date signed 5-3-48

RECEIVED

MAY 8 1948

BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04570

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution or street address where death occurred:
Allegheny Hospital
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 513 Dellen St
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Baby Girl Schriver

3. (b) Social Security Number

None

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced S

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) May 20, 1948 6.(c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
2 hrs. min.

9. Birthplace Cumberland, Allegheny, Maryland
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name Cecil Schriver

13. Birthplace Cumberland Md

MOTHER 14. Maiden name Mary Martin

15. Birthplace Md.

16. Informant Cecil Schriver

Address 513 Dellen St, Cumberland Md

17. Burial Date thereof May 21, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Peter's & Pauls Cem.

Location Cumberland Md.

18. Funeral director Louis Stein Inc.

Address Cumberland Md.

19. May 21, 1948 W. H. Hantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20, 1948 at 10:16 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 20, 1948 to May 20, 1948
and that I last saw him alive on May 20, 1948

Immediate cause of death Pneumonia

DURATION
6 mos. only

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

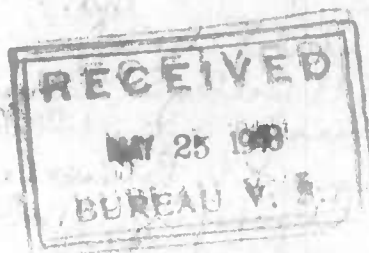
23. SIGNATURE B. M. Schriver

Address 41 Greenfield Date signed May 21, 1948

MARGIN RESERVED FOR BINDING

VS A15 3-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



DR. R. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

04571

1. PLACE OF DEATH:

County... **ALLEGANY**
City or town... **CUMBERLAND, MD.**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? **21 DAYS**
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? **21 DAYS**

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... **MARYLAND** County... **ALLEGANY**
City or town... **CUMBERLAND, MD.**
(If outside city or town limits, write RURAL and give nearest town)
Street No. **826 GREENE STREET**
(If rural, give LOCATION)
2.(a) If veteran, name war...

3. (a) FULL NAME

MR. FRANK W. SCHULTE

3. (b) Social Security Number

217-10-4569

4. Sex **MALE** 5. Color or race **WHITE** 6.(a) Single, married, widowed, or divorced **MARRIED**
6.(b) Name of husband or wife **MYRTLE DORIS HARPER**
6.(c) If alive, give age **62** years
7. Birth date of deceased (mo., day, yr.) **AUGUST 1, 1883**
8. AGE: Years **64** Months **9** Days **27** If less than one day
hrs. min.

9. Birthplace **ILLINOIS Richland**
(Town, county, and state)
10. Usual occupation **ENGINEERING DEPT. CELANESE**
11. Industry or business **CELANESE CORPORATION**
12. Name **FRANK SCHULTE**
13. Birthplace **GERMANY**
14. Maiden name **MARGARET Alfter**
15. Birthplace **GERMANY**

16. Informant **MEMORIAL HOSPITAL**
Address **MEMORIAL AVENUE, CITY**
17. Burial Date thereof **June 1, 1948**
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory **Rose Hill Cem.**
Location **Cumberland, Md.**
18. Funeral director **H. Wayne George**
Address **Cumberland, Md.**

19. **May 31, 1948** **W.R. Faub, M.D.**
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **MAY 28, 1948** at **12:27 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **June 15, 1947** to **5/27/48**
and that I last saw him alive on **5/27/48**

Immediate cause of death
Myocardial Infarction
Due to **hypertensive cardiac vascular disease 10 yrs.**
Other conditions **Emphysema of chest**
(Include pregnancy within 8 months of death)

Major findings of operations... Date of op...

Autopsy results...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Date of...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE **W.R. Faub, M.D.**
Address **Cumberland Md.** signed **5/28/48**

MARGIN RESERVED FOR BINDING

9-45-15M

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 7 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Life greatest age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04572

93d

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

124 Oak St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 124 Oak St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George F. Sheetz

3. (b) Social Security Number

705-09-9783

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Mary E.

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Oct. 26, 1892

8. AGE:

Years

Months

Days

If less than one day

55629

hrs.

min.

9. Birthplace Westernport, Md.
(Town, county, and state)10. Usual occupation Welder11. Industry or business B&O.R.R.12. Name Charles S.13. Birthplace W.VA.14. Maiden name Marie Peters15. Birthplace W.VA.16. Informant George K. SheetzAddress 124 Oak St.17. Burial Date thereof May 28, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hill Crest Burial ParkLocation Cumberland, Md.18. Funeral director James F. ScarpelliAddress Cumberland, Md.19. May 26, 1948 Registrar John T. M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25, 1948 at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19, 42 to May 27, 48and that I last saw him alive on Apr. 1, 1948

Immediate cause of death

Coronary Thrombosis

DURATION

SuddenDue to chronic myocarditis 6 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clayton Surratt

M. D. or other

Address Cumberland Date signed 5/25/48

RECEIVED

JUN 2 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

181

04573

4

ALM No. G 116 JUL 6 1948 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegheny
City or town Potomac Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. R 785 Cumberland, Md.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Patricia May Shelley

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

February 26, 1947

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

1211

hrs.

min.

9. Birthplace

Cumberland, Allegheny Co., Md.
(Town, county, and state)

10. Usual occupation

Child

11. Industry or business

12. Name

Phillip Donlon Shelley Sr.

13. Birthplace

Eckhart Mines, Md.

14. Maiden name

Hazel T. Jones

15. Birthplace

Cumberland, Md.

16. Informant

Phillip D. Shelley Sr.

Address

R 785 Cumberland, Md.

17. Burial

Date thereof May 10, 1948

(Burial, cremation, or removal, which)

Cemetery or crematory

St Ambrose Catholic Cemetery

Location

Cresaptown, Md.

18. Funeral director

John J. Haler

Address

Cumberland, Md.

19. May 10, 1948

(Date rec'd by registrar)

W. L. Rautz, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7, 1948 at 9:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4, 1948 to May 7, 1948 and that I last saw him alive on May 7, 1948

Immediate cause of death

Second aneurysm of
all three trunks on forearms
chest & upper abdomen.

Due to

DURATION

4 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Acc. Date of 5/5/48Where did injury occur? Cumberland, Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Burned self with hot steam Injured at work?

23. SIGNATURE

John J. Haler M.D.

M. D. or other

Address Ra Vale, Md. Date signed 4/9/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

E. Bing

RECEIVED
MAY 18 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

04574

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

116 Blaul Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Bedford County BedfordCity or town Bedford
(If outside city or town limits, write RURAL and give nearest town)Street No. Bedford
(If rural, give LOCATION) ✓

2. (a) If veteran, name war

3. (a) FULL NAME

Anna S. Smith

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 2, 1973

8. AGE: Years Months Days If less than one day

75

4

29

hrs.

min.

9. Birthplace Bedford County Pa.
(Town, county, and state)10. Usual occupation Cook11. Industry or business County Home at Bedford, Pa.12. Name Joseph Cobler13. Birthplace Bedford County, Pa.14. Maiden name Mary Smith15. Birthplace Bedford County, Pa.16. Informant Claude B. SmithAddress 116 Blaul Ave.17. Burial Date thereof June 3, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Wood Meth. Cem.Location Rainsburg, Pa.18. Funeral director James F. ScarpelliAddress Cumberland, Md.19. June 2, 1948 N.R. Trantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31, 1948 3:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24, 1948 to May 31, 1948and that I last saw him alive on May 31, 1948

Immediate cause of death

Carcinoma of the throat

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

J. Bailey Hunter MD

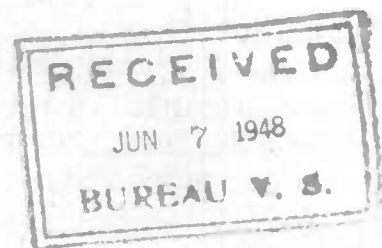
M. D. or other

Address 116 Blaul Ave Cumberland Md Date signed 6/1/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

04575

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HospitalHow long in hospital or institution? 13 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNA. County BEDFORDCity or town BEDFORD
(If outside city or town limits, write RURAL and give nearest town)Street No. R.F.D.#2
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

D. RAY SMITH

3. (b) Social Security Number

None

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

MARRIED6.(b) Name of husband or wife ANNA E. NAUGLE6.(c) If alive, give age 53 years

7. Birth date of

deceased (mo., day, yr.)

MARCH 5, 1894

8. AGE:

Years

Months

Days

If less than one day

54212

hrs.

min.

9. Birthplace

PENNA.Bedford County
(Town, county, and state)

10. Usual occupation

State Road Commissioner

11. Industry or business

Bedford County, Penna

FATHER

12. Name

DAVID R. SMITH

13. Birthplace

OHIO

MOTHER

14. Maiden name

~~BARBARA SMITH~~Lucie Snively

15. Birthplace

Bedford County, Penna

16. Informant

MEMORIAL HOSPITAL

Address

CUMBERLAND, MD.

17.

(Burial, cremation, or removal. Which?)

Date thereof

May 20, 1948
(month) (day) (year)

Cemetery or crematory

Cressna Ceph

Location

Cressna, Penna.

18. Funeral director

Address

Wm. B. GuiseBedford Penna

19.

(Date rec'd by registrar)

May 17, 1948W. J. Tantz, M.D.

Registrar

MEDICAL CERTIFICATION

NOON

20. DATE OF DEATH MAY 17 19 48 at 12:00 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

May 4 19 48 to May 17 19 48and that I last saw him on May 17 19 48

Immediate cause of death

DURATION

Cardiovascular

Due to

renal disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

None

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

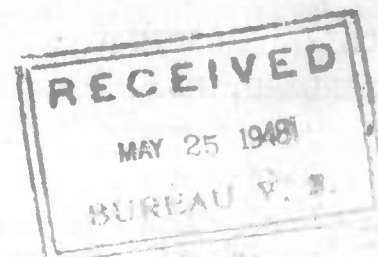
Injured at work?

23. SIGNATURE

W. J. Tantz

M. D.

Address Cumberland Date signed 5/17/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04576

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 HRS 15 MI.

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 14 HRS 15 MIN

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 219 HUMBIRD ST.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MRS VICTORIA TASKER

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

FEMALE WHITE WIDOW

6.(b) Name of husband or wife JOHN TASKER

7. Birth date of deceased (mo., day, yr.) DEC July 27, 1883
6.(c) If alive, give age years

8. AGE: Years 64 Months 9 Days 6 If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation HWEE

11. Industry or business

12. Name JAMES TASKER

13. Birthplace Oakland, Maryland

14. Maiden name ELEANOR SHROUT

15. Birthplace Oakland Maryland

16. Informant Mrs. John Clark

Address 219 Humbird St. City

17. Burial Date thereof May 5-1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Oakland

Location Oakland md

18. Funeral director Emory Bolden

Address Oakland md

19. May 3 19 48 W.P. Faugh, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 3 19 48 at 4:15 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 19 48 to May 3, 19 48

and that I last saw him alive on May 2, 19 48

Immediate cause of death

Left Pulmonary Infarct 3 days

Due to Coronary Sclerosis 2 wks

Other conditions

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE clays. J. J. J.

Address Cumberland M. D. or other 5/3/48

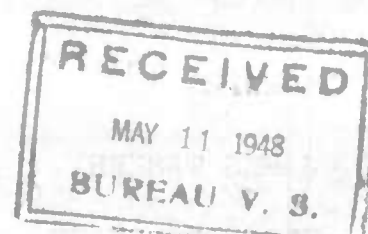
Date signed

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.



Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 4

04577

97

1. PLACE OF DEATH: Allegany
County
City or town: Near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 Years
Hospital, institution, or street address where death occurred:
Rt. 3, Bowman's Addn
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rt. 3, Bowman's Addn
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Charles E. VanPelt
3. (b) Social Security Number: None

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widowed
6. (b) Name of husband or wife: Mary (Sauers) Van Pelt
6. (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): November 26 1876
8. AGE: Years: 71 Months: 5 Days: 21 If less than one day: hrs. min.

MEDICAL CERTIFICATION
20. DATE OF DEATH: May 17 19 48 at 7-30 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 3 19 47 to May 17 19 48
and that I last saw him alive on May 10 19 48

Immediate cause of death: Generalized arteriosclerosis
DURATION: 2 yrs.

9. Birthplace: Harrisonburg, Rockingham Co. Virginia
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: 11
12. Name: Henry VanPelt
13. Birthplace: Harrisonburg, Va.
14. Maiden name: Jane May
15. Birthplace: Harrisonburg, Va.

Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

16. Informant: Kermit VanPelt
Address: Rt 3, Cumberland, Md.
17. Burial: 5/19/48
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory: Fountain Cemetery
Location: (Near) Keyser, W. Va.
18. Funeral director: William H. Kight
Address: Cumberland, Md.

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. Bling M.D.
M. D. or other: M.D.
Address: 59 Greene St. Date signed: 5-17-48

19. May 19 19 48 W.D. Fantz M.D.
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

L. Brin's

RECEIVED

MAY 25 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred
Meiners Hospital
 How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Garrett
 City or town mt. Lake Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION) ☒
 2. (a) if veteran, name war _____

3. (a) FULL NAME

Charles E. Walsh

3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife margaret Walsh
 7. Birth date of deceased (mo., day, yr.) August 26, 1872 6. (c) If alive, give age _____ years
 8. AGE: Years 75 Months 9 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Frostburg, Allegany, Md.
 (Town, county, and state)
 10. Usual occupation retired laborer
 11. Industry or business W.P.A.

12. Name James Walsh
 13. Birthplace Maryland
 14. Maiden name Ella Ferrell
 15. Birthplace Maryland

16. Informant Mrs. George Smith
 Address Cumberland Md.

17. Burial Burial Date thereof June 2, 1948
 (month) (day) (year)
 Cemetery or crematory St. Michael's Cemetery
 Location Frostburg, Md.

18. Funeral director J. P. Weir
 Address Frostburg, Md.

19. 6-1 48 Miss Nancy V. Roe
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-30 19 48 at 1 4 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-14 19 48 to 5-29 19 48
 and that I last saw him alive on 5-29 19 48

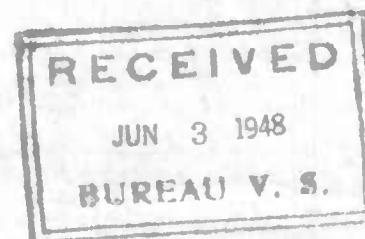
Immediate cause of death Heart failure
Arterio-sclerosis, anemia
pneumonia, pneumococci
 Due to _____
 Due to _____
 Other conditions anemia, starvation
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Edolf Walfermann M.D.
 M. D. or other _____
 Address 134 E Main St. Frostburg Date signed 5-30-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

04579

1. PLACE OF DEATH:

County... ALLEGANY

City or town... CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution? 14 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... WEST VIRGINIA County... POCAHONTAS

City or town... CLOVERLICK, W.VA.
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

HERBERT WHEELER

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

MALE

COLORED

SINGLE

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) (Unknown) 1890

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
58 hrs. min.9. Birthplace... WEST VIRGINIA
(Town, county, and state)

10. Usual occupation... Laborer

11. Industry or business... Farmwork

12. Name... EDWARD WHEELER

13. Birthplace... W.VA.

14. Maiden name... MILLIE TEMPLE

15. Birthplace... W. Va.

16. Informant... Memorial Hospital

Address... Cumberland, Maryland

17. Burial Date thereof May 16, 1948

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory... Brownsburg Cem.

Location... Brownsburg, W. Va.

18. Funeral director... H. Wayne George

Address... Cumberland, Md.

19. May 14, 1948 W. D. Trout, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... MAY 13 1948 at 11:05 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 29 1948 to May 13 1948

and that I last saw him alive on May 13 1948

Immediate cause of death... Uremia

DURATION

Due to... Chronic glomerular nephritis

Due to... Hypertension

Other conditions... Subarchnoid Hemorrhage

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results... same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... George M. Simon

Address... Memorial Hospital Date signed May 13, 1948

M. D. or other

RECEIVED

MAY 18 1948

BUREAU V. 3.